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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 9F3O

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00619

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245473**

2.STATE VENDOR OR MEDICAID NO.
(L2) **747642000**

3. NAME AND ADDRESS OF FACILITY
(L3) **OAK TERRACE HEALTH CARE CENTER**
(L4) **640 THIRD STREET**
(L5) **GAYLORD, MN** (L6) **55334**

4. TYPE OF ACTION: **7** (L8)

1. Initial	2. Recertification
3. Termination	4. CHOW
5. Validation	6. Complaint
7. On-Site Visit	9. Other
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/25/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **46** (L18)

13.Total Certified Beds **46** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	46			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Mary Rogers, HFE NE II — 11/25/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist 12/12/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 12/15/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/03/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245473	A. Building B. Wing	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
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **11/05/2014**	ID Prefix **F0247** Reg. # **483.15(e)(2)** LSC	Correction Completed **11/04/2014**	ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **11/04/2014**
ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **11/05/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	JS/KJ	12/02/2014	29437	11/25/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/16/2014			

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00619	A. Building B. Wing	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 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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **20800** Reg. # **MN Rule 4658.0510 Subp. 1** LSC	**11/05/2014**	ID Prefix **21426** Reg. # **MN St. Statute 144A.04 Subd. 4** LSC	**11/25/2014**	ID Prefix **21695** Reg. # **MN Rule 4658.1415 Subp. 4** LSC	**11/04/2014**
ID Prefix **21805** Reg. # **MN St. Statute 144.651 Subd. 5** LSC	**11/04/2014**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	JS/KJ	12/02/2014	29437	11/25/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 10/16/2014

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 9F3O

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00619

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(L1) **245473**

2.STATE VENDOR OR MEDICAID NO.
(L2) **747642000**

3. NAME AND ADDRESS OF FACILITY
(L3) **OAK TERRACE HEALTH CARE**
(L4) **CENTER 640 THIRD STREET**
(L5) **GAYLORD, MN** (L6) **55334**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/16/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **46** (L18)

13.Total Certified Beds **46** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	46			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Mary Rogers, HFE NE II 11/10/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 12/02/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 12/03/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 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

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

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

DEPARTMENT CONTACT

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

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. 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

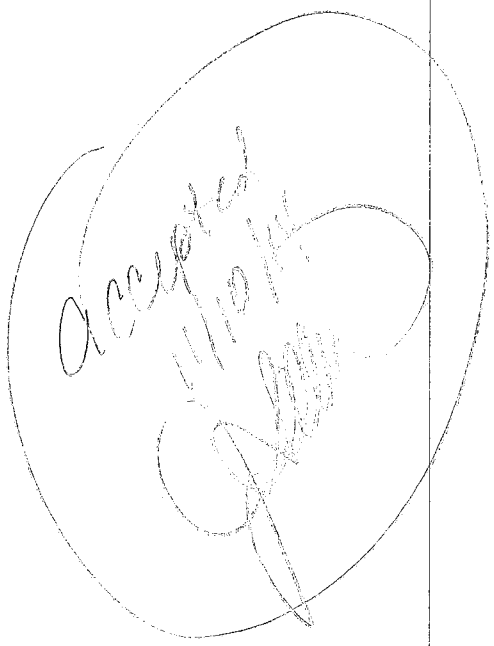
Feel free to contact me if you have questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245473	A. BUILDING _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TERRACE HEALTH CARE CENTER	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide dignified care and services with toileting assistance for 1 of 1 resident (R3), observed for toileting assistance. Findings include: R3's annual Minimum Data Set (MDS) dated 8/14/14, identified R3 had moderate cognitive impairment and required extensive staff assistance for transfers and toilet use. R3's bowel and bladder assessment dated 10/8/14, indicated, "[R3] is continent of bowel and bladder. [R3] is alert and oriented and is aware of	F 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ~~TITLE~~ Director — (X6) DATE: 11-4-14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245473	A. BUILDING _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TERRACE HEALTH CARE CENTER	640 THIRD STREET GAYLORD, MN 55334

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F 241	Continued From page 1 the need to void, so is able to alert staff to the need for assistance PRN [as needed]." The assessment identified R3 required 1:1 assist with transfers and was at risk for incontinence related to decreased mobility, decreased manual dexterity, and daily use of diuretic medication. Staff were to assist R3 with toileting as needed per the residents request. R3's care plan dated 8/14/14, identified R3 had impaired incontinence related to requiring assistance with all transfers, and the residents toileting plan was identified as, "Per his request." During observation on 10/15/14, at 9:28 a.m. R3 was sitting in the recliner 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 noticed R3's call light was on and went in to R3's room. On 10/15/2014, at 9:47 a.m. R3 was in his motorized chair in the hallway. When R3 was asked how he was doing, R3 looked down, closed his eyes, shook his head, and stated, "Just had an accident." My son walked all over looking for someone. I had to go so bad, I was just shaking. It hurt so much." R3 stated he had been waiting a long time for the staff to come and assist him to the bathroom, and he couldn't wait 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."	F 241	**F241: Director of Nurses spoke with resident R3 and his son on 10/15/14 at 11:13 a.m. and apologized for his embarrassment and lack of timely response. DON also reiterated with all the staff on 10/15/14 that timely call response is our goal.** **Dignified care is always our goal and all resident's rights pertaining to such were reviewed by the DON at the staff meeting on 11/5/14. All licensed staff personal have been instructed to assist with call lights when necessary and to daily monitor the Certified Nursing Assistants response.** **11/5/14 DON** **The call light software was repaired on 10/21/14 and the call light log is being reviewed daily and printed periodically as needed by the DON or her designee. Any response time greater than 10 minutes is investigated with staff and/or resident. This will be reviewed at our Quality Assurance Quarterly meeting in January 2015.** **11/4/14 DON & Administrator**	

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F 241	Continued From page 2 During interview on 10/15/2014, at 12:14 p.m. NA-D stated R3 had been incontinent of stool that morning and stated R3 had, "Never done that before. He always makes it on time...I'm sure he was embarrassed...I had to clean him up." NA-D stated a man had told her R3 needed to go to the bathroom and R3's call light had been on, however, NA-D was not sure how long the call light had been on. Review of R3's Bowel Log for the month of 10/14, R3 was continent with each of the 16 documented bowel movements between 10/1/14, and 10/14/14. On 10/15/14, an incontinent bowel episode was documented. During interview on 10/15/14, at 1:14 pm R3's family member (FM)-C stated they had been in the facility before when R3 turned his call light on for assistance to go to the bathroom and it takes a long time to get help. FM-C stated this morning he walked all over looking for someone to help R3 use the bathroom. When he couldn't find anyone, he went to the front desk and told them R3 needed to use the bathroom, "Bad." FM-C stated, "[R3] was just shaking...[R3] was in so much pain from trying to hold it..." [R3] is wearing Depends [a product used for incontinence]. They [staff] tell him to just go in his Depends if he can't hold it." FM-C stated he thought R3 had waited about 20 minutes for assistance earlier that morning. FM-C stated he had told staff R3's, "Odor" had gotten bad over last couple weeks and noticed it as soon as he walks into R3's room. FM-C stated this is not the first time R3 had an incontinent stool, and it happens when he has to wait for long periods of time for assistance. FM-C stated, "They just don't have enough	F 241	**System Enhancement: As of 10/15/14 we have implemented a change in staffing duties requiring housekeeping personnel to pass water to residents and make resident beds. This staffing change eliminates these duties for nursing assistants and gives them more time to answer call lights. We have also instituted an "all hands on deck" call so that during heavy call light times, other departments can be summoned to the floor. This policy will be shared with all departments.**	

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F 241	Continued From page 3 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 9/4/14, 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 or interviews with staff regarding the complaints of R3's long wait times.	F 241		

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F 241	Continued From page 4 A policy for dignified care and services of residents was requested, but not provided.	F 241		
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure appropriate notice of room/ roommate change was provided for 3 of 5 residents (R11, R41 and R26), who reported they were not informed prior to a room and/or roommate change. Findings include: R11's Minimum Data Set (MDS) dated 8/18/14, identified the resident had no cognitive impairment. During interview on 10/13/14, at 4:53 p.m. R11 stated they had not received notification from the facility prior to the current roommate moving in to their shared resident room. R41's MDS dated 10/3/14, indicated the resident had severely impaired cognition. During interview on 10/13/14, at 9:34 a.m. R41 denied receiving notification from the facility prior to the current roommate moving in to their shared resident room.	F 247	**F247: During the week of 10/26 - 10/31/14, all licensed staff members were approached, and oral education was provided about the new Room Move Procedure (see attachment B) and the resident's right to receive a notification. On November 5th, 2014, education will be provided to all licensed staff at the Licensed Staff Meeting about the new Room Move Procedure and the resident's right to receive a notification of a room or roommate change. All licensed staff recognizes that the resident, his/her family, and /or responsible party must be informed of a room change or that the resident will have anew roommate.**	

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F 247	Continued From page 5 During interview on 10/14/14, at 3:50 p.m. the director of social services verified R11 was not given notice prior to a roommate moving in to the shared resident room on 8/12/14, and R41 was not given notice prior to a roommate moving in to the shared resident room on 10/6/14. R26's MDS dated 9/28/14, identified the resident had no cognitive impairment. During interview on 10/15/14, at 11:20 a.m. R26 denied receiving notification from the facility prior to two separate roommates moving in their shared resident room within the past several months and stated, "They [roommates] just showed up." During interview on 10/15/14, at 2:17 p.m. director of nursing (DON) stated there should have been written documentation in the chart regarding a roommate change for any resident who had a room or roommate change. During interview on 10/16/14, at 10:25 a.m. director of social services stated R26 was not given a notice prior to either roommate moving in to the shared resident room which had taken place in the last several months. The facility policy titled Room Move Procedure dated 2/14, indicated social services was to initiate the process by sending out a change of status notification and schedule for move. Social services was to inform the resident, his/her family, or responsible party of the date/time and reason for a move occurring.	F 247	**Social Services will initiate the process by informing Licensed Nursing staff of all resident moves and the room number the resident is going to move to. A schedule for the move will include date, time frame for the move, and departmental/staff responsibilities before, during and after the move. Social Services will verbally and /or with the Room Change Dispute form, inform the resident, his/her family, and /or responsible party of the date and time of the move and reason for the move. If a resident, his/her family, and/or responsible party chose to dispute the room move, a Room Change Dispute form will be filled out per resident's rights. Social Services will inform the roommate, his/her family, and/or responsible party that the resident will have a new roommate. If Social Services is unavailable for the notification, the person assigned by Social Services or the Director of Nurses will initiate the notification and document the notification in the residents electronic chart.** **11/4/14 SS Director**	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES	F 253		

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F 253	Continued From page 6 The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure housekeeping and maintenance services necessary to maintain an odor free and sanitary environment were provided for 1 of 2 residents (R20) reviewed with environmental concerns. Findings include: R20's quarterly Minimum Data Set (MDS) dated 9/14/14, identified R20 had no cognitive impairment, had an indwelling Foley catheter, and required extensive assist from staff for toileting and personal hygiene. During observation on 10/13/14, at 5:31 p.m., R20's room had an overwhelming smell of urine. R20 was interviewed at that time and stated his room smelled like urine. R20 stated he had a roommate up until a couple of weeks ago, and the roommate also had a Foley catheter. R20 stated his past roommate would empty his urine into urinals and leave the urinals all over the room for staff to collect. R20 stated he had complained about the strong smell of urine to staff many times, however, the urine smell was still in his room. 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.	F 253		

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

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F 253	Continued From page 7 During interview on 10/15/14, at 9:04 a.m. housekeeping (H)-A stated R20's room had a strong smell of urine and it was like a, "Haze in the room." H-A stated housekeeping wiped down all the furniture and washed the floors in the room daily, but the urine smell did not go away. H-A stated maybe the urine odor was, "In the curtains or walls." 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. During environmental tour on 10/15/14, at 12:56 p.m. H-B and maintenance (M)-A confirmed the strong urine odor in R20's room. They both stated they had been aware of the urine smell in the room, but thought the urine odor had gotten better when the roommate moved out a few weeks ago. H-B was unsure of when the privacy curtains had last been cleaned and stated the curtains were not on a cleaning schedule. M-A suggested the facility could have tried cleaning the heating/cooling unit which was next to the former roommate's bed to see if it helped with the urine odor, and H-B stated the mattress of the prior roommate could have been swapped out as well if needed to try to get rid of the urine odor. M-A and H-B stated none of these things had been completed to try to get rid of the urine odor in R20's room. A review of the maintenance log revealed no requests for odor eliminating services in R20's room.	F 253	**F253: Resident 20 odor issue was addressed. On 10/15/14 the maintenance worker cleaned the room heater. On 10/16/14 housekeeping supervisor took down privacy curtains, washed them and re-installed them. The mattress and framework of the roommates' bed was examined and found to be odor free and an air freshener was installed. Also on 10/16 the maintenance supervisor re-examined the heater and thoroughly cleaned all the coils. Audits of this room are being logged daily by the housekeeping staff and reviewed daily by housekeeping supervisor.** **System Change: a Room Odor policy and log have been developed listing all areas and resident rooms to be examined on a daily basis (see attachment A). This policy was shared with all maintenance and housekeeping staff on 11/4/15 by the housekeeping and maintenance supervisors. Divider curtains have been put on a 6-month rotation for cleaning.**	**10/15/14 HK supervisor** **11/4/15 HK supervisor**

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F 253	Continued From page 8 A policy was requested but not provided.	F 253		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to consistently provide sufficient nursing staff to meet resident's needs in a timely manner for 12 of 39 residents (R59, R25, R11, R17, R53, R72, R20, R76, R54, R44, R26, R3), and 4 of 5 family members (FM-C, FM-D, FM-E, FM-G), who complained of not receiving timely assistance with activities of daily living (ADL's).	F 353	**F353: Residents 59, 25, 11, 17, 53, 72, 20, 76, 54, 44 ,26 and 3 care plans were reviewed in detail at the Interdisciplinary Care Team meeting on 10/30/14 and are being reviewed additionally on 11/6/14, again at the Interdisciplinary Team meeting. Every resident citied above and/or family member is also being interviewed during the week of 11/3/14 to 11/7/14 by the Social Services Director to discuss resident frustrations and hear resident suggestions.** **System Enhancement: As of 10/15/14 we have implemented a change in staffing duties requiring housekeeping personnel to pass water to residents and make resident beds. This staffing change eliminates these duties for nursing assistants and gives them more time to answer call lights. We have also instituted an "all hands on deck" call so that during heavy call light times, other departments can be summoned to the floors. This policy will be shared with all department heads on 11/4/14.** **11/5/14 DON** **11/4/14 DON** **& Administrator**	

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F 353	Continued From page 9 Findings include: R59's diagnoses on the Admission Record dated 5/7/14, included overactive bladder and spinal stenosis. R59's 14 day Minimum Data Set (MDS) dated 9/29/14, identified R59 had moderate cognitive impairment and required extensive assistance of one staff for transferring, dressing, toilet use, and personal hygiene. During interview on 10/13/14, at 5:20 p.m. R59 stated there was not enough staff to provide assistance to the bathroom. R59 stated he has to wait up to 30 minutes for help to go to the bathroom, and sometimes he has, "Accidents [urinating or bowel movement in his pants]," because he has to wait so long for help. During interview on 10/16/14, at 1:26 p.m. maintence (M)-B stated he was unable to provide any call light logs for R59 due to technical difficulties. R25's diagnoses on the Admission Record dated 9/13/13, included Parkinson's disease, difficulty in walking, and osteoporosis. R25's annual MDS dated 9/24/14, identified R25 had moderate cognitive impairment and required limited assistance of one staff with dressing and personal hygiene, and supervision with toilet use. During interview on 10/14/14, at 8:45 a.m. R25 stated she did not feel the facility had enough staff available because she often had to wait to go to bed at night, and was frustrated because she could not lay down when she wanted. During an interview on 10/16/14, at 1:26 p.m. M-B	F 353	**The call light software was repaired on 10/21/14 and the call light log is being reviewed daily and printed periodically as needed by the DON or her designee. Any response time greater than 10 minutes is investigated with staff and/or resident. This will be reviewed at our Quality Assurance Quarterly meeting in January 2015.** **11/4/14 Administrator** **11/4/14 DON**	

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F 353	Continued From page 10 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 light response times. A review of R25's incomplete call light logs for the partial month of 9/14, provided by M-B indicated the following: On 9/1/14, at 6:43 p.m. R25's call light was on for 29:00 minutes. On 9/10/14, at 6:58 p.m. R25's call light was on for 29:58 minutes. On 9/13/14, at 6:07 a.m. R25's call light was on for 37:55 minutes. On 9/27/14, at 6:17 a.m. R25's call light was on for 33:29 minutes. R11's diagnoses on the Admission Record dated 3/10/05, included pain in joints and soft tissue of limbs, stress incontinence, history of fall, and osteoarthritis. R11's annual MDS dated 8/28/14, identified R11 had no cognitive impairment and required extensive assistance of one staff for transferring, dressing, and toileting. During interview on 10/13/14, at 4:50 p.m. R11 stated the facility did not have enough staff because she had to sit and wait while she is in the bathroom, and at times she can't go to the bathroom when she needed to because there is not enough staff to assist her to the bathroom. R11 stated sometimes she will go in her pants because she cant wait anymore. R11 stated at times she has to wait up to 30-45 minutes sitting on the toilet waiting for help and, "It's not easy	F 353	**Discussions have been held with other facilities to garner creative staffing ideas since the shortage throughout Minnesota is currently at 1,800 Certified Nursing Assistant positions. We are re-entering a new contractual agreement with Sibley East High School for Certified Nursing Assistants on-site training, which allows our facility to have additional trained staff on hand to answer the residents' calls. We are also working with our local workforce center and have hired staff out of the FastTrac Certified Nursing Assistant students educated through our facility. The Administrator is on the Workforce Council at the Leading Age of Minnesota Department of Labor and Industry to find solutions to this crisis. The DON is on the Care Cabinet at the Leading Age to garner additional ideas for staffing. We currently have 6 Certified Nursing Assistants enrolled in the Health Support Specialist Program through the Leading Age Minnesota to bring more creative concepts to Oak Terrace. We have been involved in this program since 2/1/14.**	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 11 sitting on a toilet that long. It's all the time." During interview on 10/16/14, at 1:26 p.m. 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 R11's incomplete call light logs for the partial month of 9/14, provided by M-B indicated the following: On 9/1/14, at 5:10 p.m. R11's call light was on for 59:32 minutes. On 9/6/14, at 7:24 a.m. R11's call light was on for 35:26 minutes. On 9/8/14, at 5:24 p.m. R11's call light was on for 40:09 minutes. On 9/11/14, at 5:43 a.m. R11's call light was on for 48:05 minutes. On 9/12/14, at 6:22 a.m. R11's call light was on for 34:43 minutes. On 9/14/14, at 6:05 p.m. R11's call light was on for 37:06 minutes. On 9/27/14, at 6:10 p.m. R11's call light was on for 30:09 minutes. On 9/28/14, at 5:08 p.m. R11's call light was on for 43:28 minutes. On 9/29/14, at 7:36 a.m. R11's call light was on for 33:43 minutes. R17's diagnoses on the Admission Record dated 9/19/14, included generalized pain, history of fall, and hip fracture. R17's admission MDS dated 9/30/14, identified R17 had no cognitive impairment and required extensive assistance of	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245473	A. BUILDING _____ B. WING _____	10/16/2014

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F 353	Continued From page 12	F 353		

one staff for transfers, dressing, and toileting.

During interview on 10/13/14, at 7:16 p.m. R17 stated there wasn't enough staff to meet the resident's needs. R17 stated, "The girls have too many patients to take care of; It can take an hour sometimes to get help."

During interview on 10/16/14, at 1:26 p.m. maintence (M)-B stated he was unable to provide any call light logs for R17 due to technical difficulties.

R53's diagnoses on the Admission Record dated 3/18/14, included chronic kidney disease and history of fall. R53's quarterly MDS dated 8/12/14, identified R53 had no cognitive impairment and required extensive assistance for transferring and toileting.

During interview on 10/13/14, at 4:24 p.m. R53 stated she had to wait for someone to answer her call light for up to a half hour in the past. R53 stated, "At night, I had to wait and I wet myself. I was embarrassed... [staff] said don't worry about it, and it was okay...I am on those fluid pills...I put my light on and they could not get here in time."

During observation on 10/15/14, at 8:03 a.m. R53 was laying in bed and had her call light on. Nursing assistant (NA)-E entered R53's room, turned off the residents call light, and told the resident someone would be in soon to help her. At 8:46 a.m., 43 minutes after NA-E turned off R53's call light and told her someone would be in to assist her with cares, NA-F entered R53's room to assist the resident.

During interview on 10/16/14, at 1:26 p.m.

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F 353	Continued From page 13 maintence (M)-B stated he was unable to provide any call light logs for R53 due to technical difficulties. R72's diagnoses on the Admission Record dated 9/17/14, included chronic airway obstruction and acute kidney failure. R72's admission MDS dated 9/30/14, identified R72 had no cognitive impairment and needed extensive assistance for transfers, dressing, and toileting. During interview on 10/14/14, at 8:39 a.m. R72 stated, "Sunday was awful. Two [staff] didn't show up for work and they weren't replaced. She [staff] had all of the people to get up... I didn't get up until 8:30. I thought I was going to miss breakfast." R72 stated in the past he has had to wait to use the bathroom for up to half an hour. During a follow up interview on 10/14/14, at 2:15 p.m. R72 and family member (FM)-D, stated R72 didn't drink water when he was first admitted to the facility because he had to wait to use the bathroom and didn't want to go to the bathroom in his pants. FM-D stated R72 gets very uncomfortable waiting for staff to help him to the bathroom and stated, "There's nothing worse than needing to go to the bathroom and not being able to!" During an interview on 10/16/14, at 1:26 p.m. 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.	F 353		

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F 353	Continued From page 15 check into it... No response." R20's care conference notes did not address R20 had talked about concerns of lack of staffing and not having his needs met. During interview on 10/16/14, at 1:26 p.m. 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 R20's incomplete call light logs for the partial month of 9/14, provided by M-B indicated the following: On 9/27/14, at 6:04 a.m. R20's call light was on for 36:31 minutes. On 9/30/14, at 8:06 a.m. R20's call light was on for 32:45 minutes. On 9/30/14, at 5:15 p.m. R20's call light was on for 50:53 minutes. During interview on 10/14/14, at 1:56 p.m. NA-D stated R20 had complained about having to wait for along time to have his call light answered. NA-D stated she had talked to RN-A and LPN-B about the long call light response times, but there had been no change in staffing. R76's diagnoses on the Admission Record dated 10/6/14, included urinary tract infection and fatigue. R76's entry MDS dated 10/6/14, identified R76 had no cognitive impairment and required extensive assistance with transfers, dressing, hygiene, and toileting.	F 353		

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F 353	Continued From page 14 A review of R72's incomplete call light logs for the partial month of 9/14, provided by M-B indicated the following: On 9/26/14, at 6:11 a.m. R72's call light was on for 36:12 minutes. On 9/27/14, at 8:26 p.m. R72's call light was on for 34:49 minutes. R20's diagnoses on the Admission Record dated 3/5/12, included neurogenic bladder and generalized pain. R20's quarterly MDS dated 9/16/14, identified R20 had no cognitive impairment and required extensive assistance with transfers, dressing, and toileting. During interview on 10/13/14, at 5:33 p.m. R20 stated he has had to wait up to an hour and 15 minutes to get help to wash himself. R20 stated staffing was worse on weekends and during shift change, and he had complained about the lack of staffing to registered nurse (RN)-A, licensed practical nurse (LPN)-B, LPN-A, and had also discussed it several times during care conferences with the director of nursing (DON) and social worker (SW)-A. R20 stated, "There's no response to the complaints at all." R20 stated the facility still did not have enough staff to provide assistance with cares. During interview on 10/15/14, at 2:32 p.m. R20's family member, FM-E, stated R20 had talked about concerns with long call light times at care conferences several times. FM-E stated, "Yesterday, [R20's] light was on for 30 minutes; [R20] waits in his own BM [bowel movement]... We bring it up at every conference. A month ago, we brought it up again...[DON], [SW-A], and [administrator] were all there. [DON] said she'd	F 353		

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F 353	Continued From page 16 During interview on 10/13/14, at 6:42 p.m. R76 stated there was not enough staff to meet the needs of the residents. R76 stated when the residents are in the dining room, they [residents] all talk about having to wait for a long time for assistance with ADL's and are frustrated. During interview on 10/16/14, at 1:26 p.m. maintence (M)-B stated he was unable to provide any call light logs for R76 due to technical difficulties. R54's diagnoses on the Admission Record dated 9/11/14, included polymyalgia rheumatica and depression. R54's admission MDS dated 9/24/14, identified the resident had moderate cognitive impairment and required extensive assistance with transfers, dressing, and toilet use. During interview on 10/13/14, at 4:27 p.m. R54 stated when he turns his call light on, it can take a half hour before the staff come to his room to assist him. R54 stated he has bladder issues, and it takes too long for staff to come assist him, he often had to urinate in his pants. R54 stated, "When I have to go, I have to go. I can't wait a half hour. I get frustrated." During interview on 10/16/14, at 1:26 p.m. maintence (M)-B stated he was unable to provide any call light logs for R54 due to technical difficulties. R44's diagnoses on the Admission Record dated 3/5/13, included dementia and generalized muscle weakness. R44's quarterly MDS dated 9/2/14, identified R44 had severe cognitive impairment and required extensive assistance	F 353		

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F 353	Continued From page 17 with transfers, dressing, and toilet use. During interview on 10/13/14, at 7:17 p.m. R44's family member, FM-G, stated while visiting the facility recently during the evening, FM-G looked all over the facility and was unable to locate any staff to assist R44 with cares. During interview on 10/16/14, at 1:26 p.m. maintence (M)-B stated he was unable to provide any call light logs for R44 due to technical difficulties. R26's diagnoses on the Admission Record dated 3/20/13, included urinary incontinence and generalized pain. R26's quarterly MDS dated 10/1/14, identified the resident had no cognitive impairment and required extensive assistance with transferring and toileting. During interview on 10/13/14, at 4:20 p.m. R26 stated, "They don't have enough help. There's usually only one aide on each of the hallways...They are always in such a rush...They don't wash me up as well as I would like." R26 stated at meal times there is not enough staff to assist her to the dining room and she had to pull herself down the hallway on the railing, which she stated is difficult because she has no feeling in her fingers. R26 stated weekends are the worst with short staffing, and she had complained to the DON, but stated the DON doesn't do anything about it and stated, "I feel ignored." During observation on 10/14/14, at 2:26 p.m. R26's call light cord did not reach the chair in the residents room she sits in. During interview on 10/14/14, at 2:26 p.m. NA-D	F 353		

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F 353	Continued From page 18	F 353		

stated when R26 sat in the chair in her room, the call light cord was too short to reach. Staff had given R26 a bell to use to call staff for assistance. NA-D stated during a recent weekend shift she was working alone because another NA called in and wasn't replaced. When NA-D went on break, no one covered the unit where R26 resided. NA-D stated R26 needed assistance and "Rang the bell like crazy, but no one heard the bell." NA-D stated R26 was very frustrated about the incident.

During another interview on 10/14/14, at 3:01 p.m. R26 stated she was frustrated the call light cord wasn't long enough to reach the chair where she sat in her room because staff can't hear the bell when she rings it. R26 stated she talked to "all" of the staff, and the maintenance man, and told them call light did not reach her chair and staff didn't always hear her bell, but the facility had done nothing. R26 stated she had complained about short staffing to the DON and SW-A, but stated staffing has not gotten any better.

During interview on 10/16/14, at 1:26 p.m. maintence (M)-B stated he was unable to provide any call light logs for R26 due to technical difficulties.

During interview on 10/14/14, at 1:56 p.m. NA-D stated R26 had complained about long wait times to have her call light answered and not having her needs met. NA-D stated she had told RN-A and LPN-B about R26 complaining about not having her needs met due to short staffing, however, NA-D stated the lack of staffing to meet resident needs has not changed.

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F 353	Continued From page 19 R3's diagnoses on the Admission Record dated 2/20/14, included rheumatoid arthritis and enlarged prostate. R3's annual MDS dated 8/14/14, identified R3 had moderate cognitive impairment and required extensive assistance for transfers and toilet use. During observation on 10/15/14, at 9:28 a.m. R3 was in his recliner in his room and was grimacing and shaking and stated he needed to go to the bathroom. R3's son was in the hallway and stated he had gone to the desk 10 minutes ago to get some help for his Dad, and he was looking all over the hallways trying to find someone. About a minute later, NA-D came down the hall and entered R3's room. During interview on 10/15/2014, at 9:47 a.m. R3 was asked how his day was going and he looked down, closed his eyes, shook his head, and stated, "Just had an accident... My son walked all over looking for someone. I had to go so bad, I was just shaking; It hurt so much." R3 stated he had been waiting, "a long time," for the staff to come and assist him to the bathroom, and he couldn't wait any longer, resulting in incontinence of stool. R3 continued to look down, shaking his head, and stated, "It's embarrassing." During interview on 10/15/2014, at 12:14 p.m. NA-D stated R3 was incontinent of stool earlier that morning and stated R3 had, "Never done that before. He always makes it on time...I'm sure he was embarrassed...I had to clean him up." NA-D stated a man had told her R3 needed to go to the bathroom and the call light was on also, however, NA-D was unsure how long the resident had been waiting for assistance.	F 353		

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F 353	Continued From page 20 During interview on 10/15/14, at 1:14 pm R3's family member, (FM)-C, stated, "This isn't the first time. [R3] pushes his button and it takes a long time to get help." FM-C stated this morning he walked all over looking for someone to help R3 use the bathroom and when he couldn't find anyone he went to the front desk and told them R3, "Needed to use the bathroom bad." FM-C thought R3 had been waiting about 20 minutes for assistance. FM-C stated, R3, "Was just shaking...[R3] was in so much pain from trying to hold it...It's been getting worse over the past few months...[R3] is wearing Depends [a product used for incontinence]. They tell him to just go in his Depends if he can't hold it." FM-C stated he had mentioned to staff that R3's "odor" had gotten bad over last couple weeks and stated he notices the odor as soon as you walk in the room. FM-C stated this incontinent episode was not the first time, and it happened quite a bit when R3 has to wait for assistance for long periods of time. During interview on 10/15/14, at 3:00 p.m. DON stated she had received a complaint from R3's family member that R3 had to wait a long time to get help to use the bathroom. DON stated she was unable to pull up the call light log to verify how long R3's call light was on because the facility was having, "Technical difficulties with their system." DON stated she listened to R3's family member's complaint, extended an apology, and told him she would check into it. During interview on 10/16/14, at 1:26 p.m. 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	F 353		

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F 353	Continued From page 22 stated she completed call light response time audits monthly for Quality Assurance. DON stated the average call light response time was 5 minutes. DON provided a call light audit from 1/1/14 through 3/1/14, which was not readable due to the size of the print. DON provided another audit for 7/14, showing random rooms listed with call light response times. No other audits were available. DON stated she was unable to pull up the call light logs due to, "Technical difficulties." DON stated attempts are made to replace staff if someone calls in, however, sometimes they cant be replaced and they need to work short staffed. DON stated residents had complained to her about long call light times and not getting cares provided timely. DON stated she apologizes to the residents and listens to their complaints. A staffing policy was requested, but was not provided.	F 353		

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F 353	Continued From page 21 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 9/4/14, 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 an interview on 10/15/2014, at 9:31 a.m. NA-E stated the mornings can be difficult to get all of the residents cares done and stated there are times when they are not able to get all the residents out to breakfast by 9:00 a.m. During interview on 10/15/14, at 12:49 p.m. NA-G stated most days are busy and she isn't always able to get all of the resident cares completed. NA-G stated some days she needed to decide what resident cares not to complete, such as a resident's exercises or straightening up their room. NA-G stated she had brought up concerns of short staffing to management in the past, but the short staffing had not improved. During interview on 10/15/14, at 2:11 p.m. SW-A stated she did not remember any residents and/ or staff coming to her about short staffing, however, she would refer those complaints to the DON. During interview on 10/15/14, at 2:51 p.m. DON	F 353		

A

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.

Daily Housekeeping Log

Room
Oak - 11

	November	December	January	February	March	April
1						
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B

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 plan to transfer you/your loved one to room

_____ from room _____.

The reason for this room transfer is:

_____.

Your concerns or disagreement regarding 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

Social Services
Oak Terrace Health Care Center
640 3rd Street
Gaylord, MN 55334
507-237-8704

Notice Received By:

_____ _____
Resident Date

_____ _____
Facility Representative Date

_____ _____
Responsible Party Date

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245473	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/14/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TERRACE HEALTH CARE CENTER	**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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 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.	K 000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245473	A. BUILDING **02 - 2008 ADDITION** B. WING _____	**10/14/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TERRACE HEALTH CARE CENTER	**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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 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.	K 000		

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

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

and the Time Period For Correction.

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00619	A. BUILDING: _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TERRACE HEALTH CARE CENTER	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On October 13th, 14th, 15th and 16th, 2014, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00619	A. BUILDING: _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Continued From page 1 Compliance Monitoring, Licensing and Certification Program, 3333 West Division St, Suite 212, St Cloud, MN 56301.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements.	2 800		

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	00619	A. BUILDING: _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 800	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to consistently provide sufficient nursing staff to meet resident's needs in a timely manner for 12 of 39 residents (R59, R25, R11, R17, R53, R72, R20, R76, R54, R44, R26, R3), and 4 of 5 family members (FM-C, FM-D, FM-E, FM-G), who complained of not receiving timely assistance with activities of daily living (ADL's). Findings include: R59's diagnoses on the Admission Record dated 5/7/14, included overactive bladder and spinal stenosis. R59's 14 day Minimum Data Set (MDS) dated 9/29/14, identified R59 had moderate cognitive impairment and required extensive assistance of one staff for transferring, dressing, toilet use, and personal hygiene. During interview on 10/13/14, at 5:20 p.m. R59 stated there was not enough staff to provide assistance to the bathroom. R59 stated he has to wait up to 30 minutes for help to go to the bathroom, and sometimes he has, "Accidents [urinating or bowel movement in his pants]," because he has to wait so long for help. During interview on 10/16/14, at 1:26 p.m. maintence (M)-B stated he was unable to provide any call light logs for R59 due to technical difficulties. R25's diagnoses on the Admission Record dated 9/13/13, included Parkinson's disease, difficulty in walking, and osteoporosis. R25's annual MDS dated 9/24/14, identified R25 had moderate cognitive impairment and required limited	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00619	A. BUILDING: _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 3 assistance of one staff with dressing and personal hygiene, and supervision with toilet use. During interview on 10/14/14, at 8:45 a.m. R25 stated she did not feel the facility had enough staff available because she often had to wait to go to bed at night, and was frustrated because she could not lay down when she wanted. During an interview on 10/16/14, at 1:26 p.m. 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 light response times. A review of R25's incomplete call light logs for the partial month of 9/14, provided by M-B indicated the following: On 9/1/14, at 6:43 p.m. R25's call light was on for 29:00 minutes. On 9/10/14, at 6:58 p.m. R25's call light was on for 29:58 minutes. On 9/13/14, at 6:07 a.m. R25's call light was on for 37:55 minutes. On 9/27/14, at 6:17 a.m. R25's call light was on for 33:29 minutes. R11's diagnoses on the Admission Record dated 3/10/05, included pain in joints and soft tissue of limbs, stress incontinence, history of fall, and osteoarthritis. R11's annual MDS dated 8/28/14, identified R11 had no cognitive impairment and required extensive assistance of one staff for transferring, dressing, and toileting. During interview on 10/13/14, at 4:50 p.m. R11	2 800		

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2 800	Continued From page 4 stated the facility did not have enough staff because she had to sit and wait while she is in the bathroom, and at times she can't go to the bathroom when she needed to because there is not enough staff to assist her to the bathroom. R11 stated sometimes she will go in her pants because she cant wait anymore. R11 stated at times she has to wait up to 30-45 minutes sitting on the toilet waiting for help and, "It's not easy sitting on a toilet that long. It's all the time." During interview on 10/16/14, at 1:26 p.m. 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 R11's incomplete call light logs for the partial month of 9/14, provided by M-B indicated the following: On 9/1/14, at 5:10 p.m. R11's call light was on for 59:32 minutes. On 9/6/14, at 7:24 a.m. R11's call light was on for 35:26 minutes. On 9/8/14, at 5:24 p.m. R11's call light was on for 40:09 minutes. On 9/11/14, at 5:43 a.m. R11's call light was on for 48:05 minutes. On 9/12/14, at 6:22 a.m. R11's call light was on for 34:43 minutes. On 9/14/14, at 6:05 p.m. R11's call light was on for 37:06 minutes. On 9/27/14, at 6:10 p.m. R11's call light was on for 30:09 minutes. On 9/28/14, at 5:08 p.m. R11's call light was on for 43:28 minutes.	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00619	A. BUILDING: _____ B. WING _____	10/16/2014

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2 800	Continued From page 5 On 9/29/14, at 7:36 a.m. R11's call light was on for 33:43 minutes. R17's diagnoses on the Admission Record dated 9/19/14, included generalized pain, history of fall, and hip fracture. R17's admission MDS dated 9/30/14, identified R17 had no cognitive impairment and required extensive assistance of one staff for transfers, dressing, and toileting. During interview on 10/13/14, at 7:16 p.m. R17 stated there wasn't enough staff to meet the resident's needs. R17 stated, "The girls have too many patients to take care of; It can take an hour sometimes to get help." During interview on 10/16/14, at 1:26 p.m. maintence (M)-B stated he was unable to provide any call light logs for R17 due to technical difficulties. R53's diagnoses on the Admission Record dated 3/18/14, included chronic kidney disease and history of fall. R53's quarterly MDS dated 8/12/14, identified R53 had no cognitive impairment and required extensive assistance for transferring and toileting. During interview on 10/13/14, at 4:24 p.m. R53 stated she had to wait for someone to answer her call light for up to a half hour in the past. R53 stated, "At night, I had to wait and I wet myself. I was embarrassed... [staff] said don't worry about it, and it was okay...I am on those fluid pills...I put my light on and they could not get here in time." During observation on 10/15/14, at 8:03 a.m. R53 was laying in bed and had her call light on. Nursing assistant (NA)-E entered R53's room, turned off the residents call light, and told the	2 800		

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2 800	Continued From page 6	2 800		

resident someone would be in soon to help her. At 8:46 a.m., 43 minutes after NA-E turned off R53's call light and told her someone would be in to assist her with cares, NA-F entered R53's room to assist the resident.

During interview on 10/16/14, at 1:26 p.m. maintence (M)-B stated he was unable to provide any call light logs for R53 due to technical difficulties.

R72's diagnoses on the Admission Record dated 9/17/14, included chronic airway obstruction and acute kidney failure. R72's admission MDS dated 9/30/14, identified R72 had no cognitive impairment and needed extensive assistance for transfers, dressing, and toileting.

During interview on 10/14/14, at 8:39 a.m. R72 stated, "Sunday was awful. Two [staff] didn't show up for work and they weren't replaced. She [staff] had all of the people to get up... I didn't get up until 8:30. I thought I was going to miss breakfast." R72 stated in the past he has had to wait to use the bathroom for up to half an hour.

During a follow up interview on 10/14/14, at 2:15 p.m. R72 and family member (FM)-D, stated R72 didn't drink water when he was first admitted to the facility because he had to wait to use the bathroom and didn't want to go to the bathroom in his pants. FM-D stated R72 gets very uncomfortable waiting for staff to help him to the bathroom and stated, "There's nothing worse than needing to go to the bathroom and not being able to!"

During an interview on 10/16/14, at 1:26 p.m. M-B stated the facility was having technical difficulties with their call log system, and was only able to

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2 800	Continued From page 7	2 800		

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 R72's incomplete call light logs for the partial month of 9/14, provided by M-B indicated the following:

On 9/26/14, at 6:11 a.m. R72's call light was on for 36:12 minutes.
On 9/27/14, at 8:26 p.m. R72's call light was on for 34:49 minutes.

R20's diagnoses on the Admission Record dated 3/5/12, included neurogenic bladder and generalized pain. R20's quarterly MDS dated 9/16/14, identified R20 had no cognitive impairment and required extensive assistance with transfers, dressing, and toileting.

During interview on 10/13/14, at 5:33 p.m. R20 stated he has had to wait up to an hour and 15 minutes to get help to wash himself. R20 stated staffing was worse on weekends and during shift change, and he had complained about the lack of staffing to registered nurse (RN)-A, licensed practical nurse (LPN)-B, LPN-A, and had also discussed it several times during care conferences with the director of nursing (DON) and social worker (SW)-A. R20 stated, "There's no response to the complaints at all." R20 stated the facility still did not have enough staff to provide assistance with cares.

During interview on 10/15/14, at 2:32 p.m. R20's family member, FM-E, stated R20 had talked about concerns with long call light times at care conferences several times. FM-E stated,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00619	A. BUILDING: _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TERRACE HEALTH CARE CENTER	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 8 "Yesterday, [R20's] light was on for 30 minutes; [R20] waits in his own BM [bowel movement]... We bring it up at every conference. A month ago, we brought it up again...[DON], [SW-A], and [administrator] were all there. [DON] said she'd check into it... No response." R20's care conference notes did not address R20 had talked about concerns of lack of staffing and not having his needs met. During interview on 10/16/14, at 1:26 p.m. 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 R20's incomplete call light logs for the partial month of 9/14, provided by M-B indicated the following: On 9/27/14, at 6:04 a.m. R20's call light was on for 36:31 minutes. On 9/30/14, at 8:06 a.m. R20's call light was on for 32:45 minutes. On 9/30/14, at 5:15 p.m. R20's call light was on for 50:53 minutes. During interview on 10/14/14, at 1:56 p.m. NA-D stated R20 had complained about having to wait for along time to have his call light answered. NA-D stated she had talked to RN-A and LPN-B about the long call light response times, but there had been no change in staffing. R76's diagnoses on the Admission Record dated 10/6/14, included urinary tract infection and	2 800		

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2 800	Continued From page 9	2 800		

fatigue. R76's entry MDS dated 10/6/14, identified R76 had no cognitive impairment and required extensive assistance with transfers, dressing, hygiene, and toileting.

During interview on 10/13/14, at 6:42 p.m. R76 stated there was not enough staff to meet the needs of the residents. R76 stated when the residents are in the dining room, they [residents] all talk about having to wait for a long time for assistance with ADL's and are frustrated.

During interview on 10/16/14, at 1:26 p.m. maintence (M)-B stated he was unable to provide any call light logs for R76 due to technical difficulties.

R54's diagnoses on the Admission Record dated 9/11/14, included polymyalgia rheumatica and depression. R54's admission MDS dated 9/24/14, identified the resident had moderate cognitive impairment and required extensive assistance with transfers, dressing, and toilet use.

During interview on 10/13/14, at 4:27 p.m. R54 stated when he turns his call light on, it can take a half hour before the staff come to his room to assist him. R54 stated he has bladder issues, and it takes too long for staff to come assist him, he often had to urinate in his pants. R54 stated, "When I have to go, I have to go. I can't wait a half hour. I get frustrated."

During interview on 10/16/14, at 1:26 p.m. maintence (M)-B stated he was unable to provide any call light logs for R54 due to technical difficulties.

R44's diagnoses on the Admission Record dated 3/5/13, included dementia and generalized

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	00619	A. BUILDING: _____ B. WING _____	10/16/2014

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2 800	Continued From page 10 muscle weakness. R44's quarterly MDS dated 9/2/14, identified R44 had severe cognitive impairment and required extensive assistance with transfers, dressing, and toilet use. During interview on 10/13/14, at 7:17 p.m. R44's family member, FM-G, stated while visiting the facility recently during the evening, FM-G looked all over the facility and was unable to locate any staff to assist R44 with cares. During interview on 10/16/14, at 1:26 p.m. maintence (M)-B stated he was unable to provide any call light logs for R44 due to technical difficulties. R26's diagnoses on the Admission Record dated 3/20/13, included urinary incontinence and generalized pain. R26's quarterly MDS dated 10/1/14, identified the resident had no cognitive impairment and required extensive assistance with transferring and toileting. During interview on 10/13/14, at 4:20 p.m. R26 stated, "They don't have enough help. There's usually only one aide on each of the hallways...They are always in such a rush...They don't wash me up as well as I would like." R26 stated at meal times there is not enough staff to assist her to the dining room and she had to pull herself down the hallway on the railing, which she stated is difficult because she has no feeling in her fingers. R26 stated weekends are the worst with short staffing, and she had complained to the DON, but stated the DON doesn't do anything about it and stated, "I feel ignored." During observation on 10/14/14, at 2:26 p.m. R26's call light cord did not reach the chair in the residents room she sits in.	2 800		

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2 800	Continued From page 11 During interview on 10/14/14, at 2:26 p.m. NA-D stated when R26 sat in the chair in her room, the call light cord was too short to reach. Staff had given R26 a bell to use to call staff for assistance. NA-D stated during a recent weekend shift she was working alone because another NA called in and wasn't replaced. When NA-D went on break, no one covered the unit where R26 resided. NA-D stated R26 needed assistance and "Rang the bell like crazy, but no one heard the bell." NA-D stated R26 was very frustrated about the incident. During another interview on 10/14/14, at 3:01 p.m. R26 stated she was frustrated the call light cord wasn't long enough to reach the chair where she sat in her room because staff can't hear the bell when she rings it. R26 stated she talked to "all" of the staff, and the maintenance man, and told them call light did not reach her chair and staff didn't always hear her bell, but the facility had done nothing. R26 stated she had complained about short staffing to the DON and SW-A, but stated staffing has not gotten any better. During interview on 10/16/14, at 1:26 p.m. maintence (M)-B stated he was unable to provide any call light logs for R26 due to technical difficulties. During interview on 10/14/14, at 1:56 p.m. NA-D stated R26 had complained about long wait times to have her call light answered and not having her needs met. NA-D stated she had told RN-A and LPN-B about R26 complaining about not having her needs met due to short staffing, however, NA-D stated the lack of staffing to meet resident needs has not changed.	2 800		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TERRACE HEALTH CARE CENTER	640 THIRD STREET GAYLORD, MN 55334

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2 800	Continued From page 12 R3's diagnoses on the Admission Record dated 2/20/14, included rheumatoid arthritis and enlarged prostate. R3's annual MDS dated 8/14/14, identified R3 had moderate cognitive impairment and required extensive assistance for transfers and toilet use. During observation on 10/15/14, at 9:28 a.m. R3 was in his recliner in his room and was grimacing and shaking and stated he needed to go to the bathroom. R3's son was in the hallway and stated he had gone to the desk 10 minutes ago to get some help for his Dad, and he was looking all over the hallways trying to find someone. About a minute later, NA-D came down the hall and entered R3's room. During interview on 10/15/2014, at 9:47 a.m. R3 was asked how his day was going and he looked down, closed his eyes, shook his head, and stated, "Just had an accident... My son walked all over looking for someone. I had to go so bad, I was just shaking; It hurt so much." R3 stated he had been waiting, "a long time," for the staff to come and assist him to the bathroom, and he couldn't wait any longer, resulting in incontinence of stool. R3 continued to look down, shaking his head, and stated, "It's embarrassing." During interview on 10/15/2014, at 12:14 p.m. NA-D stated R3 was incontinent of stool earlier that morning and stated R3 had, "Never done that before. He always makes it on time...I'm sure he was embarrassed...I had to clean him up." NA-D stated a man had told her R3 needed to go to the bathroom and the call light was on also, however, NA-D was unsure how long the resident had been waiting for assistance.	2 800		

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	00619	A. BUILDING: _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 800	Continued From page 13 During interview on 10/15/14, at 1:14 pm R3's family member, (FM)-C, stated, "This isn't the first time. [R3] pushes his button and it takes a long time to get help." FM-C stated this morning he walked all over looking for someone to help R3 use the bathroom and when he couldn't find anyone he went to the front desk and told them R3, "Needed to use the bathroom bad." FM-C thought R3 had been waiting about 20 minutes for assistance. FM-C stated, R3, "Was just shaking...[R3] was in so much pain from trying to hold it...It's been getting worse over the past few months...[R3] is wearing Depends [a product used for incontinence]. They tell him to just go in his Depends if he can't hold it." FM-C stated he had mentioned to staff that R3's "odor" had gotten bad over last couple weeks and stated he notices the odor as soon as you walk in the room. FM-C stated this incontinent episode was not the first time, and it happened quite a bit when R3 has to wait for assistance for long periods of time. During interview on 10/15/14, at 3:00 p.m. DON stated she had received a complaint from R3's family member that R3 had to wait a long time to get help to use the bathroom. DON stated she was unable to pull up the call light log to verify how long R3's call light was on because the facility was having, "Technical difficulties with their system." DON stated she listened to R3's family member's complaint, extended an apology, and told him she would check into it. During interview on 10/16/14, at 1:26 p.m. 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	2 800		

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2 800	Continued From page 14	2 800		

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 9/4/14, 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 an interview on 10/15/2014, at 9:31 a.m. NA-E stated the mornings can be difficult to get all of the residents cares done and stated there are times when they are not able to get all the residents out to breakfast by 9:00 a.m.

During interview on 10/15/14, at 12:49 p.m. NA-G stated most days are busy and she isn't always able to get all of the resident cares completed. NA-G stated some days she needed to decide what resident cares not to complete, such as a resident's exercises or straightening up their room. NA-G stated she had brought up concerns of short staffing to management in the past, but the short staffing had not improved.

During interview on 10/15/14, at 2:11 p.m. SW-A stated she did not remember any residents and/or staff coming to her about short staffing, however, she would refer those complaints to the DON.

During interview on 10/15/14, at 2:51 p.m. DON stated she completed call light response time audits monthly for Quality Assurance. DON stated

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2 800	Continued From page 15 the average call light response time was 5 minutes. DON provided a call light audit from 1/1/14 through 3/1/14, which was not readable due to the size of the print. DON provided another audit for 7/14, showing random rooms listed with call light response times. No other audits were available. DON stated she was unable to pull up the call light logs due to, "Technical difficulties." DON stated attempts are made to replace staff if someone calls in, however, sometimes they cant be replaced and they need to work short staffed. DON stated residents had complained to her about long call light times and not getting cares provided timely. DON stated she apologizes to the residents and listens to their complaints. A staffing policy was requested, but was not provided. SUGGESTED METHOD OF CORRECTION: Facility administration and the director of nursing could utilize employee, resident and family input to evaluate staffing patterns and identify times/ places where those staffing patterns could/should be adjusted and implement those adjustments in order to meet all resident needs in a timely manner. Facility policies and procedures for sufficient staffing could be reviewed/ revised. Pertinent employees could be retrained on those policies/ practices. Audit tools could be developed to observe for timely and complete care, meeting all resident needs as identified in their care plan. The facility's Quality Assessment & Assurance committee could review those findings and develop/ implement corrective actions for any patterns or root/cause determinations for on-going compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		

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	00619	A. BUILDING: _____ B. WING _____	10/16/2014

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21426	MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to 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.	21426		

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	00619	A. BUILDING: _____ B. WING _____	10/16/2014

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21426	Continued From page 17 R28 was admitted to the facility on 3/3/12. R28's record lacked evidence of a completed TB symptom screen. R39 was admitted to the facility on 4/26/14. R39's record lacked evidence of a completed TB symptom screen. 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 the facility on 9/11/14. R54's record lacked evidence of a completed TB symptom screen. During interview on 10/14/14, at 3:55 p.m. director of nursing (DON) stated the facility only completed TB symptom screens for employees, and stated screenings were not completed for residents. NA-A was hired by the facility on 7/2/14. NA-A's employee record lacked evidence of both the two step TB test, and the TB symptom screen. During interview on 10/14/14, at 3:38 p.m. human resources (HR) stated the TB testing on employees was initiated on orientation. HR stated the DON would check through the completed forms periodically, but it wasn't anyone's responsibility to monitor them. HR confirmed NA-A's record lacked evidence of TB testing and screening. During interview on 10/14/14, at 3:55 p.m. DON stated she would complete the two step TB testing for employees and wasn't sure why NA-A's record lacked evidence of being	21426		

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	00619	A. BUILDING: _____ B. WING _____	10/16/2014

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21426	Continued From page 18 completed. The DON stated HR had a checklist to ensure each employee's record contained all the required data and wasn't sure why NA-A did not have the two step TB test or the TB symptom screen. The facility policy TB Testing for Staff, undated, indicated all employees must provide documentation of a negative reaction to a TB test before providing direct care to clients. The facility's Tuberculosis Screening, Prevention, and Control Program dated 6/8/14, lacked direction related to completing symptom screening of newly admitted residents. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could provide education to staff to address the importance of tuberculosis monitoring. The director of nursing or designee could develop an auditing system to ensure all residents and employees receive their TB symptom screening and tuberculin skin testing. The quality assurance and assessment committee could establish a system to audit tuberculosis testing to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting,	21695		

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21695	Continued From page 19 and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure housekeeping and maintenance services necessary to maintain an odor free and sanitary environment were provided for 1 of 2 residents (R20) reviewed with environmental concerns. Findings include: R20's quarterly Minimum Data Set (MDS) dated 9/14/14, identified R20 had no cognitive impairment, had an indwelling Foley catheter, and required extensive assist from staff for toileting and personal hygiene. During observation on 10/13/14, at 5:31 p.m., R20's room had an overwhelming smell of urine. R20 was interviewed at that time and stated his room smelled like urine. R20 stated he had a roommate up until a couple of weeks ago, and the roommate also had a Foley catheter. R20 stated his past roommate would empty his urine into urinals and leave the urinals all over the room for staff to collect. R20 stated he had complained about the strong smell of urine to staff many times, however, the urine smell was still in his room. 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. During interview on 10/15/14, at 9:04 a.m. housekeeping (H)-A stated R20's room had a strong smell of urine and it was like a, "Haze in	21695		

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	00619	A. BUILDING: _____ B. WING _____	10/16/2014

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21695	Continued From page 20	21695		

the room." H-A stated housekeeping wiped down all the furniture and washed the floors in the room daily, but the urine smell did not go away. H-A stated maybe the urine odor was, "In the curtains or walls."

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.

During environmental tour on 10/15/14, at 12:56 p.m. H-B and maintenance (M)-A confirmed the strong urine odor in R20's room. They both stated they had been aware of the urine smell in the room, but thought the urine odor had gotten better when the roommate moved out a few weeks ago. H-B was unsure of when the privacy curtains had last been cleaned and stated the curtains were not on a cleaning schedule. M-A suggested the facility could have tried cleaning the heating/cooling unit which was next to the former roommate's bed to see if it helped with the urine odor, and H-B stated the mattress of the prior roommate could have been swapped out as well if needed to try to get rid of the urine odor. M-A and H-B stated none of these things had been completed to try to get rid of the urine odor in R20's room.

A review of the maintenance log revealed no requests for odor eliminating services in R20's room.

A policy was requested but not provided.

SUGGESTED METHOD OF CORRECTION:
The facility maintenance/ environmental services

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	00619	A. BUILDING: _____ B. WING _____	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TERRACE HEALTH CARE CENTER	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21695	Continued From page 21 director could assess for a root cause of the urine odor in the resident's room and implement cleaning/ maintenance/ replacement processes as needed to remove the odor. Facility policies and procedures could be reviewed/ revised, with re-education on these policies provided to pertinent employees. Facility administration and maintenance personnel could develop auditing tools to evaluate this and other resident's rooms for homelike qualities. Results from those audits could be reviewed by the facility's Quality Assessment & Assurance committee for input and oversight for on-going compliance efforts. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide dignified care and services with toileting assistance for 1 of 1 resident (R3), observed for toileting assistance. Findings include: R3's annual Minimum Data Set (MDS) dated 8/14/14, identified R3 had moderate cognitive impairment and required extensive staff	21805		

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21805	Continued From page 22	21805		

assistance for transfers and toilet use.

R3's bowel and bladder assessment dated 10/8/14, indicated, "[R3] is continent of bowel and bladder. [R3] is alert and oriented and is aware of the need to void, so is able to alert staff to the need for assistance PRN [as needed]." The assessment identified R3 required 1:1 assist with transfers and was at risk for incontinence related to decreased mobility, decreased manual dexterity, and daily use of diuretic medication. Staff were to assist R3 with toileting as needed per the residents request.

R3's care plan dated 8/14/14, identified R3 had impaired incontinence related to requiring assistance with all transfers, and the residents toileting plan was identified as, "Per his request."

During observation on 10/15/14, at 9:28 a.m. R3 was sitting in the recliner 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 noticed R3's call light was on and went in to R3's room.

On 10/15/2014, at 9:47 a.m. R3 was in his motorized chair in the hallway. When R3 was asked how he was doing, R3 looked down, closed his eyes, shook his head, and stated, "Just had an accident." My son walked all over looking for someone. I had to go so bad, I was just shaking. It hurt so much." R3 stated he had been waiting a long time for the staff to come and assist him to the bathroom, and he couldn't wait

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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."

During interview on 10/15/2014, at 12:14 p.m. NA-D stated R3 had been incontinent of stool that morning and stated R3 had, "Never done that before. He always makes it on time...I'm sure he was embarrassed...I had to clean him up." NA-D stated a man had told her R3 needed to go to the bathroom and R3's call light had been on, however, NA-D was not sure how long the call light had been on.

Review of R3's Bowel Log for the month of 10/14, R3 was continent with each of the 16 documented bowel movements between 10/1/14, and 10/14/14. On 10/15/14, an incontinent bowel episode was documented.

During interview on 10/15/14, at 1:14 pm R3's family member (FM)-C stated they had been in the facility before when R3 turned his call light on for assistance to go to the bathroom and it takes a long time to get help. FM-C stated this morning he walked all over looking for someone to help R3 use the bathroom. When he couldn't find anyone, he went to the front desk and told them R3 needed to use the bathroom, "Bad." FM-C stated, "[R3] was just shaking...[R3] was in so much pain from trying to hold it..." [R3] is wearing Depends [a product used for incontinence]. They [staff] tell him to just go in his Depends if he can't hold it." FM-C stated he thought R3 had waited about 20 minutes for assistance earlier that morning. FM-C stated he had told staff R3's, "Odor" had gotten bad over last couple weeks and noticed it as soon as he walks into R3's room. FM-C stated this is not the first time R3

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21805	Continued From page 24	21805		

had an incontinent stool, and it happens when he has to wait for long periods of time for assistance. 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 9/4/14, 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 or interviews with staff regarding the complaints of R3's long wait

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21805	Continued From page 25 times. A policy for dignified care and services of residents was requested, 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 treatment. Facility employees could be re-educated on expectations for dignified and timely toileting assistance. Random audits of dignified and timely toileting assistance could be completed for all residents who require assistance. The facility's Quality Assessment & Assurance committee could review those findings and develop/ implement corrective actions for any patterns or root/cause determinations for on-going compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21805		