DEPARTMENT OF HEALT						DICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: 9H7F
1. MEDICARE/MEDICAID PROVID (L1) 245224 2.STATE VENDOR OR MEDICAID	DER NO.	3. NAME AND AI	DDRESS OF FAC	CILITY CARE CEN	TE SURVEY AGENCY	Facility ID: 00877 4. TYPE OF ACTION: 7(L8) 1. Initial 2. Recertification 3. Termination 4. CHOW
(L2) 721522300		(L5) HASTINGS	, MN		(L6) 55033	5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)		7. PROVIDER/SU 01 Hospital	05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 09/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	02/2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	IS CERTIFIED	AS:		
From (a):		X A. In Complia	nce With		And/Or Approved Waivers O	f The Following Requirements:
To (b):			equirements e Based On:		2. Technical Personne	
12.Total Facility Beds	91 (L18)	1	cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SI 5. Life Safety Code	7. Medical Director NF)8. Patient Room Size 9. Beds/Room
13.Total Certified Beds	91 (L17)	B. Not in Con Requirem	npliance with Prog ents and/or Appli	gram ed Waivers:	* Code: A	(L12)
14. LTC CERTIFIED BED BREAKDO	OWN	·			15. FACILITY MEETS	
18 SNF 18/19 SNF 91	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION I	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL Date:
Susanne Reuss, Supervisor	r	()9/09/2014	(L19)	Anne Kleppe, Enforce	ement Specialist 09/09/2014 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	L OFFICE OR SINGLE S	
 DETERMINATION OF ELIGIBI <u>X</u> 1. Facility is Eligible to 2. Facility is not Eligible 	Participate		IPLIANCE WITH HTS ACT:	H CIVIL		ancial Solvency (HCFA-2572) rol Interest Disclosure Stmt (HCFA-1513) /e :
	(L21)					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	/IENT	26. TERMINATION ACTION	I: (L30)
OF PARTICIPATION 11/06/1978	BEGINNINC	G DATE	ENDING DA	ГЕ	<u>VOLUNTARY</u> <u>0</u> 01-Merger, Closure	0 INVOLUNTARY 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburg	sement 06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminati	OTHER
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-1 lovider Status Change
(L27)	B. Rescind St	uspension Date:	(L44)			00-Active
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	N OF APPROVAL	DATE		
	(L32)	08/19/2014		(L33)	DETERMINATION APP	PROVAL



Protecting, Maintaining and Improving the Health of Minnesotans CMS Certification Number (CCN): 24-5224

September 9, 2014

Ms. Kay Emerson, Administrator Augustana Health Care Center of Hastings 930 West 16th Street Hastings, Minnesota 55033

Dear Ms. Emerson:

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 August 21, 2014, the above facility is certified for:

91 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 91 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

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,

Are Klegese

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Division of Compliance Monitoring, Minnesota Department of Health Email: anne.kleppe@state.mn.us Telephone: (651) 201-4124 Fax: (651) 215-9697



Protecting, Maintaining and Improving the Health of Minnesotans

September 9, 2014

Ms. Kay Emerson, Administrator Augustana Health Care Center of Hastings 930 West 16th Street Hastings, Minnesota 55033

RE: Project Number S5224023

Dear Ms. Emerson:

On July 29, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 17, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 2, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on August 22, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 17, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 21, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 17, 2014, effective August 21, 2014 and therefore remedies outlined in our letter to you dated July 29, 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,

Ane Klegge

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Email: anne.kleppe@state.mn.us Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure cc: Licensing and Certification File

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245224	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 9/2/2014
Name	e of Facility		Street Address, City, State, Zip Code	
AU	IGUSTANA HEALTH CARE CENTER	OF HASTINGS	930 WEST 16TH STREET HASTINGS, MN 55033	

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	(Y	5) Date	(Y4) Item	(Y5)	Date	(Y4) Item		(Y5)	Date
ID Prefix Reg. # LSC	F0156 483.10(b)(5) - (10), 483	Correction Completed _08/12/2014 .10(t		F0225 483.13(c)(1)(ii)-(iii), (c)(F0226 483.13(c)		Correction Completed 08/12/2014
ID Prefix Reg. #		Correction Completed 08/12/2014	ID Prefix Reg. #		Correction Completed 08/12/2014	ID Prefix			Correction Completed
ID Prefix Reg. # LSC			Reg. #		Correction Completed	Reg. #			Correction Completed
Reg. #			_		Correction Completed	D "			Correction Completed
Reg. #			Reg. #						
Reviewed I State Agen Reviewed I CMS RO		• •	Date: 09/09/20 Date:	Signature of Sur 14 Signature of Sur	-	16	022	Date: 09/0 Date:	2/2014
Followup t	o Survey Completed o 7/17/2014	n:	 	Check for any Unco Uncorrected Defic				YES	NO

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245224	(Y2) Multiple Cons A. Building B. Wing	IN BUILDING 01	(Y3) Date of Revisit 8/22/2014
Name	e of Facility		Street Address, City, State, Zip Code	
AU	GUSTANA HEALTH CARE CENTER	OF HASTINGS	930 WEST 16TH STREET HASTINGS, MN 55033	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5)	Date	(Y4) Item		(Y5)	Date	
		Correction			Correction				Correction	
ID Prefix		Completed 08/21/2014	ID Prefix		Completed 08/20/2014	ID Prefix			Completed 08/20/2014	
-	NFPA 101	_	Reg. #	NFPA 101		-	NFPA 101			
LSC	K0029	-	LSC	K0071		LSC	K0144			
		Correction			Correction				Correction	
		Completed			Completed				Completed	
		_	ID Prefix			ID Prefix				
Reg. #		-	Reg. #			Reg. #	. <u></u>		_	
		-	LSC			LSC			_	
		Correction			Correction				Correction	
		Completed			Completed				Completed	
ID Prefix		_	ID Prefix							
Reg. #		-	Reg. #			Reg. #			_	
LSC		-	LSC			LSC				
		Correction			Correction				Correction	
		Completed			Completed				Completed	
ID Prefix		_	ID Prefix			ID Prefix				
Reg. #		_	Reg. #			Reg. #				
LSC		-	LSC _			LSC				
		Correction			Correction				Correction	
		Completed			Completed				Completed	
ID Prefix		_	ID Prefix			ID Prefix				
Reg. #		_	Reg. #			Reg. #	. <u></u>			
		_				LSC				
Reviewed I			Date:	Signature of Sur	veyor:			Date:		
State Agen	cy PS/AK		09/09/20	014			25822	08/2	2/2014	
Reviewed I CMS RO	By Reviewed	d By	Date:	Signature of Sur	veyor:			Date:		
Followup t	o Survey Completed o	n:		Check for any Unco	rected Defic	iencies. Was a	Summary of	I		
	7/15/2014			Uncorrected Defic				YES	NO	

DEPARTMENT O	F HEALTH A	ND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES
						AND TRANSMITTAL	ID: 9H7F
		PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AGENCY	Facility ID: 00877
1. MEDICARE/MEDICA (L1) 245224 2.STATE VENDOR OR I (L2) 721522300		ю.	3. NAME AND AI (L3) AUGUSTAN (L4) 930 WEST 1 (L5) HASTINGS	A HEALTH C 6TH STREET	CARE CEN	TER OF HASTINGS (L6) 55033	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE C (L9)	HANGE OF OW	NERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEG 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
 DATE OF SURVEY ACCREDITATION S^T 0 Unaccredited 2 AOA 		(L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF 0 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
 11LTC PERIOD OF CE From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 	RTIFICATION	91 (L18) 91 (L17)	Complianc <u>X</u> 1. A			2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	7. Medical Director
15. Iotal Certified Beds		91 (E17)		ents and/or Appli		* Code: B	(L12)
14. LTC CERTIFIED BE	D BREAKDOWN					15. FACILITY MEETS	
18 SNF	18/19 SNF 91	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37)	(L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AC	JENCY REMARK	KS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION I	DATE):		
17. SURVEYOR SIGNA	TURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Candace Bolduc,	HFE NE II		0	08/11/2014	(L19)	Anne Kleppe, Enforcer	ment Specialist 08/19/2014 (L20)
	PART	II - TO BE	COMPLETED I	BY HCFA RE	GIONAI	COFFICE OR SINGLE S	TATE AGENCY
-	OF ELIGIBILITY is Eligible to Partic is not Eligible	ipate (L21)		IPLIANCE WITH TTS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) o :
22. ORIGINAL DATE	23	3. LTC AGREEN	MENT 24	4. LTC AGREEN	1ENT	26. TERMINATION ACTION:	: (L30)
OF PARTICIPATIO 11/06/1978	N	BEGINNING	B DATE	ENDING DAT	ГЕ	VOLUNTARY 00 01-Merger, Closure	INVOLUNTARY 05-Fail to Meet Health/Safety
(L24)		(L41)		(L25)		02-Dissatisfaction W/ Reimburs	
25. LTC EXTENSION I	DATE: 27 (L27)	A. Suspension	VE SANCTIONS n of Admissions: aspension Date:	(L44)		03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	on <u>OTHER</u> 07-Provider Status Change 00-Active
				(L45)			
28. TERMINATION DA	TE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS	
			03001			.	
		(L28)			(L31)	Posted 08/19/2014	4 Co.
31. RO RECEIPT OF CM	1 8-1539	32	. DETERMINATION	OF APPROVAL	DATE		
		(L32)			(L33)	DETERMINATION APPI	ROVAL



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 5309

July 29, 2014

Ms. Kay Emerson, Administrator Augustana Health Care Center of Hastings 930 West 16th Street Hastings, Minnesota 55033

RE: Project Number S5224023

Dear Ms. Emerson:

On July 17, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3793 Fax: (651) 201-3790

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 August 26, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 26, 2014 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

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.

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

Augustana Health Care Center of Hastings July 29, 2014 Page 4

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 October 17, 2014 (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.

Augustana Health Care Center of Hastings July 29, 2014 Page 5

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 January 17, 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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 Cedar Street, Suite 145 St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205 Fax: (651) 215-0541

Feel free to contact me if you have questions.

Augustana Health Care Center of Hastings July 29, 2014 Page 6

Sincerely,

Are Klegge

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Email: <u>anne.kleppe@state.mn.us</u> Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

Recent and

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PRINTED: 07/29/2014 FORM APPROVED

ND PLAN OF COP	EFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		245224	B. WING			07/	17/2014
NAME OF PROVI	DER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
AUGUSTANA	HEALTH CARE	CENTER OF HASTINGS			IWEST 18TH STREET STINGS, MN 55033		
(X4) ID PREFIX TAG	(EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) GOMPLETION DATE
Th		of correction (POC) will serve	F	000	"Augustana Health Care Cente Hastings" Plan of Correction i written credible ascertain of su stantial compliance with the Federal and State requirement:	s 1b-	
Der bott	partment's acce form of the first p	of compliance upon the ptance. Your signature at the bage of the CMS-2567 form will tion of compliance.	A Contraction of the second se	- Anne	Nursing facilities and/or skille nursing facilities participating the Federal Medicare or State Medical Assistance program.	d	
revi vali reg	sit of your facili date that subst	acceptable POC an on-site ty may be conducted to antial compliance with the en attained in accordance with	- 5EX	i 410 p.	Please note that nothing set for this Document is to be or show continued to be an admission Augustana Health Care Center	ild be by	
F 156 483 SS=D R10	8.10(b)(5) - (10) AHTS, RULES,	, 483.10(b)(1) NOTICE OF SERVICES, CHARGES	F	156	Hastings or employee of Augustana Health Care Center Hastings, of the validity or		
and	t in writing in a derstands of his	form the resident both crally language that the resident or her rights and all rules and ling resident conduct and			accuracy of any of the deficien cited by the Minnesota Depart of Health relative to the surve certification and enforcement	ment y,	
iac not	ility must also p ice (if any) of th	ring the stay in the facility. The rovide the resident with the le State developed under Act. Such notification must be			at issue. Further, please note the any or all documents transmitte otherwise provided by August	ted or	
ma res any	de prior to or u ident's stay. R	Act. Such homeanshifts be pon admission and during the eceipt of such information, and to it, must be acknowledged in	944-440		Health Care of Hastings in relations to this Plan of Correc as well as any and all other communications in writing or erwise by or on behalf of	oth-	
ent of a	itled to Medical admission to the	nform each resident who is id benefits, in writing, at the time e nursing facility or, when the			Augustana Health Care Center Hastings are and shell be cons to be WITHOUT PREDJUDI the rights, remedies, claims,	trued CE to	
iter fac wh	ns and service ility services un ich the resident	eligible for Medicaid of the s that are included in nursing ider the State plan and for a may not be charged; those			defenses of Augustana Health Center of Hastings, at law and equity, all of which and not w and all of which are reserves a	l/or in aived	
ani	d for which the amount of cha	ervices that the facility offers resident may be charged, and trges for those services; and penysupplier regresentatives sid		\langle	retained by, for and on behalf Augustana Health Care Cente Hastings.	of	

Any deficiency statement lending with an asterisk (*) denotes a deliciency (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 tollowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plane 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.

TATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		riple construction	(X3) DAT	. 0938-039 E SURVEY IPLETED
		245224	B. WING		07	17/2014
	ROVIDER OR SUPPLIER	CENTER OF HASTINGS		STREET ADDRESS, CITY, STATE, ZP 930 WEST 16TH STREET HASTINGS, MN 55033	CODE	1172014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDEP:S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 156	the items and serv (i)(A) and (B) of thi The facility must in at the time of admit the resident's stay, facility and of char- including any char- under Medicare or The facility must fu- legal rights which i A description of the funds, under parage A description of the for establishing eli- the right to reques 1924(c) which deter non-exempt resou- institutionalization spouse an equitab- cannot be consider toward the cost of medical care in his down to Medicaid A posting of name numbers of all per groups such as the agency, the State ombudsman progradvocacy network unit; and a statem complaint with the agency concerning	nt when changes are made to ices specified in paragraphs (5) is section. form each resident before, or ssion, and periodically during of services available in the ges for those services, ges for services not covered by the facility's per diem rate. urnish a written description of ncludes: e manner of protecting personal graph (c) of this section; a requirements and procedures gibility for Medicald, including t an assessment under section ermines the extent of a couple's roes at the time of and attributes to the community le share of resources which red available for payment the institutionalized spouse's is or her process of spending	F 14	56 Resident 111 and 159 have discharged from the facilit Residents whose Medicare will be ending will receive notices and beneficiary appleast 48 hours prior to disc skilled services. The facilit was reviewed and updated necessary. The Medicare Nurse, or he have been re-inserviced or regarding the regulation an policy for issuance of liabit A copy of the liability notit provided to the Administra- to ensure that they were is appropriate time frame. The trator will audit for compli- issues noted with the proce- referred to the facility's Q input/suggestions. The Ad- responsible for ensuring the notices and beneficiary apparts administered at least 48 hold discharge from skilled services.	y. coverage their liability peal rights at harge from ty's policy where er designee, a 8/1/2014 of facility lity notices. ces will be ator for review sued in an he Adminis- tance. Any ess will be API Team for liministrator is tat liability peal rights are purs prior to	8/6/201

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

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Facility ID: 00877

If continuation sheet Page 2 of 15

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/29/2014 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ļ''			(X3) DATI	E SURVEY PLETED
		245224	B. WING			07/	17/2014
NAME OF I	PROVIDER OR SUPPLIER	£	·	S	TREET ADDRESS, GITY, STATE, ZP CODE	1. 011	17/2014
AUGUST		CENTER OF HASTINGS		9	30 WEST 16TH STREET		
200001				ŀ	ASTINGS, MN 55033		
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C 156	Continued Tommer		Í				
F 156	· · · · · · · · · · · · · · · · · · ·	-	া ন	156			
	directives requirem	mpliance with the advance ents.					
	The facility must in	form each resident of the					
	name, specialty, ar	nd way of contacting the					
	physician responsi	ole for his or her care.					
	written Information applicants for adm information about I Medicare and Med	cominently display in the facility , and provide to residents and ission oral and written now to apply for and use icaid benefits, and how to previous payments covered by					
	by: Based on interview facility did not prov Medicare coverage R159) reviewed fo beneficiary appeal Findings include: Review of Notice of Non-Coverage for for R111 and R159 signed by recipien end of their Medicare Medicare coverage and the notice was discharged home coverage for R159 notice was signed discharged to home During interview, Of facility's Minimum	of Medicare Provider ms (CMS-10123) on 7/17/14, 0 revealed these forms were not ts at least 48 hours prior to the are coverage in the facility. 5 for R111 ended on 5/30/14, 5 signed on 5/29/14. R111 was the next day. Medicare 0 ended on 6/13/14, and the on 6/12/14. The resident was					

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FORM CMS-2567(02-89) Previous Versions Obsolete

Facility ID: 00877

If continuation sheet Page 3 of 15

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	TIPLE CONSTRUCTION		E SURVEY PLETED
		245224	B. WING _	· · · · · · · · · · · · · · · · · · ·	07/1	7/2014
	ROVIDER OR SUPPLIER	CENTER OF HASTINGS		STREET ADDRESS, CITY, STATE, ZIP C 930 WEST 16TH STREET HASTINGS, MN 55033		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 225	had to be given and The policy for Deni Indicated under Pro- there is a change is staif must notify the longer meet the co- must be issued a r 483.13(c)(1)(ii)-(iii) INVESTIGATE/RE ALLEGATIONS/IN The facility must no been found guilty of mistreating resider had a finding enter registry concerning of residents or mis and report any kno court of law agains indicate unfitness other facility staff t or licensing author The facility must e involving mistreatr including injuries of misappropriation of immediately to the to other officials in through established State survey and of The facility must h violations are thor	vo day notice from discharge d not at end of service. ial Letters, last reviewed 10/12, ocedural Step 4. B. 1: "When n the level of care: Medicare e beneficiary when they no everage criteria. A denial notice ninimum of two-day notice." , (c)(2) - (4) PORT DIVIDUALS of employ individuals who have of abusing, neglecting, or nts by a court of law; or have red into the State nurse aide g abuse, neglect, mistreatment sappropriation of their property; owledge it has of actions by a st an employee, which would for service as a nurse aide or o the State nurse aide registry rities.	F 1		under the State ed immedi- int-to-resident immediately ent-to-resident per policy a for reporting egin keeping a event log to gressive taff have been reporting, and r of required 8/9/2014. All on the facil- on and report- same time sible for ensur- sare immedi- tota Depart- imon Entry	8/12/2012

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DAT	0938-0391
		DENTROATION NUMBER.	A. BUILDING	ä	COV	MPLETED
		245224	B. WING			/17/2014
	PROVIDER OR SUPPLIER	CENTER OF HASTINGS		STREET ADDRESS, CITY, STATE, ZIP 930 WEST 16TH STREET HASTINGS, MN 55033	CODE	
(X4) 1D PREFIX TAG	(EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIK CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE
F 225	The results of all in to the administrato representative and with State law (incl certification agency incident, and if the	all investigations must be reported rator or his designated and to other officials in accordance (including to the State survey and ency) within 5 working days of the the alleged violation is verified rrective action must be taken. Clinical Practice, or her designee, will audit VA files and the facility's resident to-resident aggression log to ensure the facility is meeting regulatory guidelines Issues/concerns noted will be referred to the facility's QAPI Team for input/ suggestions.		signee, will lity's resident- to ensure the ry guidelines. be referred to		
	This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facilit failed to ensure all alleged violations involving resident to resident altercations were reported to the administrator immediately and/or reported to officials in accordance with state laws for 2 of 4 residents (R1, R2) who were reviewed.					
	Findings include:		-			
	Although the incide	an Incident with R120. ent had been reported to the id not been reported to the facility policy,				
	were involved in a admitted that day p.m. two staff mer out" and then hear members entered standing, holding a raised. R1 had wa ear. R1 was identif data set (MDS) da communicative, to behavior problems	dated 4/29/14, R1 and R120 n aftercation. R120 had been into the room with R1. At 8:45 nbers heard someone yell, "get rd slapping sounds. As the staff the room they saw R120 onto the wheelchair with hand rmth and redness to the left fied in the quarterly minimum sted 6/14, as non stal care resident with no s. A decision was made for the taken to remove R1 from the				

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TATEMENT	OF DEFICIENCIES F CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	0938-0391 E SURVEY MPLETED
		245224	B, WING		07	/17/2014
	PROVIDER OR SUPPLIEF	CENTER OF HASTINGS		STREET ADDRESS, CITY, STATE, ZIP 930 WEST 16TH STREET HASTINGS, MN 55033		1112913
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 225	night in a different R120. At approximately administrator to in documentation or 4/30/14, revealed of nursing (DON) 10:15 p.m. on 4/2 not meet the crite confused with no more importantly Review of progre 10:50 p.m. indem been moved into elevator back ups agitated, crying a leave his room bus situation that had sleep on first floc Although it had b confused with no notes dated 4/30 administrator me incident and whe said, "he annoye given as to what The administrato was not allowed then asked the a guy doing?" R12 hit anyone."	b the first floor to spend the t room, rather than moving 9;30 p.m., the staff called the nform of the incident. The a the incident report dated 5 the administrator and director discussed reportability issues at 19/14, and felt the incident did tria to report it. R120 was intent or question of intent, but no serious harm occurred to R1 ss notes, dated 4/29/14, at dified R1 left the room he had for the night and took the stairs. He was described as nd upset. R1 did not want to ut after the staff described the happened earlier, he agreed to	0	25		

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CENTERS FOR MEDICARE & MEDICAD SERVICES PORM APPROVES STATEMENT OF DEPICENCIES (01) PROUNDERGUEPUIERCUA (22) MULTIPLE CONSTRUCTION AND FLAN OF CORRECTION 245224 (22) MULTIPLE CONSTRUCTION AND OF PROVIDER OR SUPPLIER 245224 (22) MULTIPLE CONSTRUCTION AUGUSTANA HEALTH CARE CENTER OF HASTINGS STATE ZIP GODE 230 MEST LIST HISTORY STATE ZIP GODE AUGUSTANA HEALTH CARE CENTER OF HASTINGS STATE ZIP GODE STATE ZIP GODE (X1) D SUMMARY STATEMENT OF DEFICIENCIES PREFX PREFX NME OF PROVIDER OF MOVIDER DESTINGS PREFX PREFX PREFX (X2) D SUMMARY STATEMENT OF DEFICIENCIES PREFX PREFX NME OF PROVIDER OF DEFICIENCIES PREFX PREFX PREFX NG SUMMARY STATEMENT OF DEFICIENCIES PREFX PREFX NG SUMMARY STATEMENT OF DEFICIENCIES PREFX PREFX NG SUMMARY STATEMENT NOT DEFICIENCIES PREFX PREFX SUMMARY STATEMENT NOT DEFICIENCIES PREFX PREFX PREFX SUMMAR	DEPART	MENT OF HEALTH	AND HUMAN SERV	/ICES			PRINTED:	
STATEMENT OF DEPROENCIES AND PLANOF CORRECTION (01) PROVIDER OURPLIER: IDENTIFICATION NUMBER: 245224 (02) UNLITING CONSTRUCTION A BULDING A BULDING STREET ADDRESS, CITY, STATE, ZIP GODE STREET CITY, STATE, ZIP GODE STREET ADDRESS, CITY, STATE, ZIP GODE STREET CITY, STATE, ZIP GODE STREET ADDRESS, CITY, STATE, ZIP GODE STREET ADDRESS, CITY, STATE, ZIP GODE STREET CITY, STATE, ZIP GODE STREET ADDRESS, CITY, STATE, ZIP GODE STREET ADDRESS, CITY, STATE, ZIP GODE STREET STREET	CENTER	IS FOR MEDICARE	& MEDICAID SERV	/ICES				
MME OF PROVIDER OR SUPPLIER STREET ADDRESS, OTV, 8 TATE, 2P GODE AUGUSTANA HEALTH CARE CENTER OF HASTINGS STREET ADDRESS, OTV, 8 TATE, 2P GODE AUGUSTANA HEALTH CARE CENTER OF PASTINGS Street address AUGUSTANA HEALTH CARE CENTER OF PASTINGS Street address AUGUSTANA HEALTH CARE CENTER OF PERCENDS, reach DEPROCEMENT BY TATELEDED IN FULL REGULATORY OR LSC DENTIFYING INFORMATION) PREVIDER OF MAIN CONTECTION PROVIDER OF MAIN CONTECTION PROVIDER OF MAIN CONTECTION F 225 Continued From page 6 Progress notes on 4/30/14, at 115 p.m. holicated R1 was observed crying, R1 was notified would need to spend one more night out of his room and would return on 5/1/14, when R120 was moved to a private room. F 225 On 7/15/14, at 11:30 a.m., the administrator was interviewed about reporting of the incident to the state agency. The administrator runs on wilkill Intent on the part of R120 due to domenta diagnoses and adjustment after being in the Grace Unit (a behaviora). The administrator lead oning athough it might seem like R120 cid. The administrator reviewed the void any him because R1 annoys no one and has no behaviors. The administrator also indicated did not less R1 annoys no one and has no behaviors. The administrator labe indicated for protects was there had to be lement which she did in think R 120 had. She felt R120 was discompated from reality and R1 was not seriously injured by the incident a not seriously injured by the incident or resident abuse most be reported. Upon further Interview at 12:21 p.m., the administrator indicated for understanding was there had to be lement which she did in think R 120 had. She felt R120 was discompated from reality and R1 was not seriously injured by the incident or soliticated for understanding was there had to bea							(X3) DATE	SURVEY
NAME OF PROVIDER OF SUPPLIER STREET ADORES, CITY, STATE, 20 GODE AUGUSTANA HEALTH CARE CENTER OF HASTINGS STREET ADORES, CITY, STATE, 20 GODE [X4] D SUMAARY STATEMENT OF DEFICIENCIES D PREFX REGULATORY ON LSC DESTRIPTING INCOMMETCON D F225 Confinued From page 6 P Progress notes on 4/30/14, at 11:15 p.m. Indicated P Risulation of the more night out of this come P Attempts to Interview R1 on 7/16/14, when R120 was F225 On 7/16/14, at 11:30 a.m., the administrator was Interviewed about reporting of the hicklent to the some of digustment after being in the Grace Unit (a behaviorat unit). The administrator was not willful Interview R1 on 7/16/14, were unsuccessful. F225 On 7/16/14, at 11:30 a.m., the administrator was interviewed about reporting of the hicklent to the Grace Unit (a behaviorat unit). The administrator lead indigences and adjustment after being in the Grace Unit (a behaviorat unit). The administrator respland that the facility uses an algorithm to determine if resident to resident attreated dig not extend to speed for any final distret of the the was not specific distret of the Adviora. The administrator reviewed the policy and said the policy indicated from reality and R1 was not seriously indicated from reality and R1 was not seriously indicated from reality and R1 was not seriously injured by the incident. R120 red, the discommeted from reality and R1 was not seriously injured by the incident or specific R120 was not seriously injured by the incident or specific R120 was not s			245224	B. V	NING		07/1	7/2014
Audust AnvA HEALTH CARE CENTER OF HASTINGS HASTINGS, MN 55033 (M) D Preferx TAG SUMARY STATEMENT OF DEFICIENCIES (BAHT BERUSON WUST EX FACEDED BY PLU RESULATION TO ILS IDENTIFYING INFORMATION RESULATION TO ILS IDENTIFYING INFORMATION RESULATION TO ILS IDENTIFYING INFORMATION FACE PIER PROVIDERS TO THE APPROPRIATE CROSS-INFERENCE TO THE APPROPRIATE DEFIDIENCY 0000 CROSS-INFERENCE TO THE APPROPRIATE DEFIDIENCY 00000 CROSS-INFERENCE TO THE APPROPRIATE DEFIDIENCY 000000 CROSS-INFERENCE TO THE APPROPRIATE DEFIDIENCY 000000000 CROSS-INFERENCE TO THE APPROPRIATE DEFIDIENCY 000000000000000000000000000000000000	NAME OF F	ROVIDER OR SUPPLIER		<u></u>	S	TREET ADDRESS, CITY, STATE, ZIP GOI		
PARTN NG CEACH DEFICIENCY MUST BLE PRECEDED BY FULL RESULTION OR LSC IDENTIFYING INFORMATION PREFX TAG TEACH CONCOMPICATION OF ISHOLD BE CROSS-REFERENCE OT INFORMATION CONSTRUCTION OF ISHOLD BE CROSS-REFERENCE OT INFORMATION F 225 Continued From page 6 Progress notes on 4/30/14, at 11:15 p.m. indicated R If was observed or If 100 was not 164 would return on 5/1/14, when R120 was moved to a private room. F 225 On 7/16/14, at 11:30 a.m., the administrator was interviewed adjustment after being in the Grace Unit (a behavioral unit). The administrator explained that the facility was an algorithm to determine If resident to resident abuse on the private isolate and was easily agitated. The administrator reviewed the Paradoministrator The administrator indecated from waned to self isolate and was easily agitated. The administrator reviewed the polog and add the policy incleated resident to resident abuse move and constanting was there had to be intert which she did not think R R120 had. She feit R120 was classoneeted from rea	AUGUST	ANA HEALTH CARE	CENTER OF HASTIN	GS	1			
Progress notes on 4/30/14, at 1:15 p.m. Indicated R1 was observed crying. R1 was notified would need to spend one more night out of his room and would return on 5/1/14, when R120 was moved to a private room. Attempts to interview R1 on 7/16/14, were unsuccessful. On 7/16/14, at 11:30 a.m., the administrator was interviewed about reporting of the incident to the state agency. The administrator felt there was no willful Intent on the part of R120 due to dementia diagnoses and adjustment after being in the Grace Unit (a behavioral unit). The administrator explained that the facility uses an algorithm to determine if resident to resident altercations are willful. When asked what would R1 have done to annoy R120, the administrator stated did not know why R1 would annoy him because R1 annoys no one and has no behaviors. The administrator also indicated did not leel R120 understood what he was doing although It might seem like R120 did. The administrator reviewed the policy adiated. The administrator reviewed the policy adiated. The administrator reviewed the policy adiated. The administrator reviewed the policy adiated the policy indicated resident to resident abuse must be reported. Upon further interview at 12:21 p.m., the administrator indicated be runderstanding was there had to be interviewed in the he did not think R120 had. She felt R120 was disconnected from reality and R1 was not reported. The policy and procedure, titled Vulnerable Aduit Reporting and investigation Procedure revised on	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY	FULL P	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF	HOULD BE	COMPLETION
8/13, indicated under the section: "incidents that must be reported immediately to the Minnesota	F 225	Progress notes on R1 was observed of need to spend one and would return of moved to a private Attempts to intervie unsuccessful. On 7/16/14, at 11:3 interviewed about in state agency. The willful intent on the diagnoses and adji Grace Unit (a beha explained that the determine if reside willful, When asket annoy R120, the a know why R1 woul annoys no one and administrator also understood what his seem like R120 did described R120 as isolate and was ear reviewed the policy resident to resider Upon further interviad administrator indid there had to be intt R120 had. She feil reality and R1 was incident so it was in The policy and pro- Reporting and Invi- 8/13, indicated uniti-	4/30/14, at 1:15 p.m. rying. R1 was notifie more night out of hi- n 5/1/14, when R120 room. w R1 on 7/16/14, when administrator felt the part of R120 due to ustment after being in avioral unit). The administrator felt the part of R120 due to ustment after being in avioral unit). The administrator stated of d annoy him because d what would R1 hav- dministrator stated of d annoy him because i has no behaviors. Indicated did not fee e was doing althoug d. The administrator is a loner who wanted is a loner who wanted is a loner who wanted is a loner who wanted is a loner who avides in abuse must be repriew at 12:21 p.m., the ated her understand ent which she did not t R120 was disconner in not seriously injured not seriously injured hor reported. weedure, titled Vulner estigation Procedure der the section: "inc	ere rator was ere rator was ent to the re was no dementia in the ministrator rations are re done to lid not re R1 The H R120 h it might further I to self iministrator indicated ported, ne ling was ot think ected from d by the rable Adult erevised on idents that	F 225			

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PRINTED: 07/29/2014 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB_NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245224 B. WING 07/17/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 930 WEST 16TH STREET AUGUSTANA HEALTH CARE CENTER OF HASTINGS HASTINGS, MN 55033 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (X5) COMPLETION DATE łD (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TÁG DEFICIENCY) F 225 Continued From page 7 F 225 Department of Health (MDH)" Included resident to resident abuse. The policy also indicated the administrator was to be notified immediately. R2 was involved in an incident with R120 and the incident was not reported to the administrator or state agency. An incident report, dated 5/10/14 at 7:10 p.m., revealed R2 and R120 were involved in an altercation. R2 was sitting in a wheelchair in the lounge on second floor. R120 was observed standing over R2 with hands raised and according to the written incident report, R120 slapped R2 on the right arm, face and neck. After the incident R120 was removed from the area and as R120 was being removed he slapped the nursing assistant (NA) in the face. There was no Injury to R2 and R120 was sent into the Grace Unit. The administrator was not notified of the incident and the incident was not reported to the state agency. When interviewed on 7/16/14, at 11:30 a.m., the administrator indicated staff must always notify her right away and most often staff would notify the director of nursing (DON) as well. The administrator did not recall being notified of the incident on 5/10/14, and said the incident was not reported to the state agency. The administrator could not provide documentation as to why the incident between R2 and R120 was not reported. 8/12/2004 F 226 488.13(c) DEVELOP/IMPLMENT F 226 Resident 120 has been discharged from SS=D ABUSE/NEGLECT, ETC POLICIES the facility. The facility must develop and implement written policies and procedures that prohibit (CONTINUED ON NEXT PAGE) FORM CMS-2567(02-99) Previous Versions Obsolete Event ID:9H7P11 Facility ID: 00877 If continuation sheet Page 8 of 15

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PRINTED: 07/29/2014 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245224 B, WING 07/17/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 930 WEST 16TH STREET AUGUSTANA HEALTH CARE CENTER OF HASTINGS HASTINGS, MN 55033 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 226 | Continued From page 8 Any event that is reportable under the State F 226 or Federal law will be reported immedimistreatment, neglect, and abuse of residents ately per regulation. The facility's VA poland misappropriation of resident property. icy/procedure has been reviewed and updated as necessary. Staff was re-inserviced from 8/5/2014 -This REQUIREMENT is not met as evidenced 8/9/2014 on the facility's policy and proceby; dure for VA reporting including resident-to Based on interview and record review, the facility -resident aggression. Resident to resident failed to implement their policy to report resident altercations will be reported, per policy, to resident altercations to the state agency for 2 when the CMS/MDH criteria for reporting of 4 residents (R1, R2) whose reports were are met. Facility will also begin keeping a reviewed and failed to immediately notify the separate resident-to-resident event log to administrator for R2. track resident-to-resident aggressive incidents Findings include: Licensed and management staff have been reinserviced on VA policy, reporting, and The policy and procedure, titled Vulnerable Adult notification to Administrator of required Reporting and Investigation Procedure revised on incidents. All staff has been re-inserviced 8/13, indicated under the section: "Incidents that on the facility's policy for VA protection must be reported immediately to the Minnesota Department of Health (MDH)" included resident to and reporting requirements. The adminisresident abuse. The policy also indicated the trator is responsible for ensuring that all administrator was to be notified immediately, reportable events are immediately reported to the Minnesota Department of Health and On 7/16/14, at 11:30 a.m., the administrator was the Common Entry Point for vulnerable interviewed regarding a report dated 4/29/14, where R1 and R120 were involved in an adults. Augustana Care's Regional Direcaltercation. R120 had been admitted that day into tor of Clinical Practice will audit VA files the room with R1. At 8:45 p.m. two staff members and the facility's resident-to-resident agheard someone yell, "get out" and then heard gression log to ensure the facility is meetstapping sounds. As the staff members entered the room they saw R120 standing, holding onto ing regulatory guidelines. Issues/concerns the wheelchair with hand raised. R1 had warmth noted will be referred to the facility's and redness to the left ear. When asked why the QAPI Team for input/suggestions. report had not been called to the state agency, the administrator felt there was no willful intent on the part of R120 due to dementia diagnoses and adjustment after being in the Grace Unit (a

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Facility ID: 00877

If continuation sheet Page 9 of 15

PRINTED: 07/29/2014 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER; (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING 245224 B. WING 07/17/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 930 WEST 16TH STREET AUGUSTANA HEALTH CARE CENTER OF HASTINGS HASTINGS, MN 65033 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (XE) COMPLETION DATE 1D (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 226 | Continued From page 9 F 226 behavioral unit). Administrator indicated did not feel R120 understood what he was doing, although, "[R120] may seem like he did but he does not". The administrator reviewed the policy and said the policy stated resident to resident abuse must be reported to the state agency. Administrator was also interviewed at this time regarding the incident with R2 and R120 that occurred 5/10/14 at 7:10 p.m. The report revealed R2 was sitting in a wheelchair in the lounge on second floor and R120 was observed standing over R2 with hands raised. According to the written incident report, R120 slapped R2 on the right arm, face and neck. After the incident R120 was removed from the area and as R120 was being removed he slapped the nursing assistant (NA) In the face. The administrator stated that staff must always notify her right away and most often staff would notify the director of nursing (DON) as well. The administrator did not recall being notified of the incident on 5/10/14, or of it being reported to the state agency. The administrator could not provide documentation as to why the incident between R2 and R120 was not reported. F 246 Resident 20, 45, and 55 all have their call 8/12/2014 F 246 483.15(e)(1) REASONABLE ACCOMMODATION SS=D | OF NEEDS/PREFERENCES lights within reach. All residents have either the stand call A resident has the right to reside and receive light or a flat call light within reach in services in the facility with reasonable their respective rooms. Resident's care accommodations of individual needs and plans have been reviewed and updated as preferences, except when the health or safety of necessary. the individual or other residents would be Staff was re-inserviced from 8/5/2014 endangered. 8/9/2014 on the facility's policy for having the call light within reach. (CONTINUED ON NEXT PAGE)

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Facility ID: 00877

If continuation sheet Page 10 of 15

TATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/SUP IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATI	0938-039 E SURVEY PLETED
	····	245224	B. WING		07/	17/2014
NAME OF I	PROVIDER OR SUPPLIER		l	REET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF HASTINGS	1	0 WEST 16TH STREET ASTINGS, MN 55033		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 246	This REQUIREME by: Based on observa review, the facility (R20, R45, R55) c reviewed for enviro Findings include: R20's call light wai 4:52 p.m. R20 wa chair (w/c) near wi was observed han inches of cord see with call light push and unavailable fo 4:54 p.m. verified unseen and unrea mattress for R20. use the call light a for transferring. During the enviror p.m., R20 was ob cards on night tab nightstand top dra R20's call light wa 4:17 p.m. R45 wa room with no call was hooked on R hooked on the co	age 10 NT is not met as evidenced ition, interview and document falled to ensure 3 of 3 residents all lights were at reach onmental concerns. Is not accessible on 7/14/14, at is observed sitting in wheel indow in room and the call light ging down from wall, few in hanging down from panel, button unseen, out of reach ir R20 to access. NAR-D at that call light push button was ichable between wall and NAR-D stated R20 was able to ind R20 needed staff assistance amental tour on 7/17/14, at 1:09 served sitting in w/c playing ile with call light nearby in twer. The administrator verified ould be within reach while R20 its not at reach on 7/14/14, at as observed sitting in recliner in light within reach. A call light 45's bed and another one was uch. Both call lights were out of access. Surveyor called NAR-C -C verified call light placements		Audits will be done three times p week, on different shifts, by assi staff to ensure that call lights and light clips are within reach in ever resident room. Any noted issue be forwarded to the applicable n manager for appropriate follow n with the staff. Call light audits will be brought facility's QAPI meeting for input suggestions from the Team. The Administrator is responsible for ing that call lights are within rea- residents.	gned f call ery will urse up to the t/ e ensur-	

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Facility ID: 00877

If continuation sheet Page 11 of 15

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION	(X3) DAT	. 0938-039 TE SURVEY
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	PROVIDER OR SUPPLIER	245224	B. WING			07	/17/2014
		CENTER OF HASTINGS		93	TREET ADDRESS, CITY, STATE, ZIP CODE 30 WEST 16TH STREET IASTINGS, MN 55033		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 246		age 11 equired staff assistance to	F	246			
	p.m. R45 was obsiglated on bed rail,	ed R45 should have call light					
	7/15/14, and 7/16/	s not accessible on 7/14/14, 14. R55's call light was the floor under R55's bed, out o sately access.					
	sitting on the bed, floor under R55's access, Surveyor NAR-D verified tha the floor under R5 find, NAR-D picke on top of R55's be bed and NAR-D a it on top of R55's p pillow, NAR-D sta	4 p.m., R55 was observed R55's call light was lying on the bed, out of sight for R55 to called NAR-D to room and at R55's call light was lying on 5's bed and unable for R55 to d up call light and set call light ed. The call light slipped off the gain picked up call light and put offlow on bed, without clipping to ted R55 was able to use the call uld have assistance from staff to w/c.					
	sitting in a chair at no staff in sight. F and asking for toil approached R55	0 a.m., R55 was observed t the end of the hall alone with 55 was fidgity, looking around eting help. At 8:22 a.m., staff and R55 stated, "I have to go to AR-E indicated R55 flags staff i in the hall.					
		58 a.m., call light for R55 was top of bed unclipped. At 1:15					

CENTERS FOR MEDICARE & MEDICALD SERVICES Over No. 0938-0357 AND FLAN OF CORRECTION (M) PROVIDEN OR SUPPLIER (M) PROVIDENCES (M) PROVIDENCES AND OF PROVIDEN OR SUPPLIER 245224 B. WNG 07/17/2014 AUGUSTAINA HEALTH CARE CENTER OF HASTINGS 91/17/2014 91/17/2014 07/17/2014 Preferx SUMMARY STREAM OF DEFIDIENCIES 91 PROVIDERS FLAV CONFECTION 08/11/17/14/12/17/2014 Preferx EAUGUSTAINA HEALTH CARE CENTER OF HASTINGS 07/17/2014 0/11/12/01/14/17/2014 0/11/12/01/14/17/2014 F246 Continued From page 12 Preferx Preferx PROVIDER'S FLAV CONFECTION 0/16/17/2014 F246 Continued From page 12 Preferx F246 F246 Mode staff and and 11/17 pr.m., NAR-B verified F246 F246 F246 On 7/17/14, at 8:44 a.m., RN-A stated that a bell MII be scheeld F50 wild and at 11/1 pr.m., NAR-B verified F246 On 7/17/14, at 8:44 a.m., RN-A stated that a bell MII be schees it when passement for B55's call F246 On 7/17/14, at 8:44 a.m., RN-A stated that a bell MII be schees it when passement for B55's call F246 On 7/17/14, at 8:44 a.m., RN-A stated ther would op opt a not hop of B65's bed. <t< th=""><th></th><th></th><th></th><th>····+</th><th></th><th></th><th></th><th>FOR</th><th>D; 07/29/2 M APPRO</th><th>VED</th></t<>				····+				FOR	D; 07/29/2 M APPRO	VED
MAKE OF PROVIDER OR SUPPLIER Image: Contract of	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPI	PLIER/CLIA	· ·			(X3) D/	ATE SURVEY	
NAME CP PROVIDER OR SUPPLIER STREET ADDRESS, CTV, STRE, 2P CODE AUGUSTANA HEALTH CARE CENTER OF HASTINGS SUMMARY STATEMENT OF DEFICIENCES SUMMARY STATEMENT OF DEFICIENCES (X4) ID SUMMARY STATEMENT OF DEFICIENCES D PHOVEREP REVISED TO SHOULD BE COMPLETION SHOULD BE COMPLETION SHOULD BE F246 Continued From page 12 D PHOVEREP ROFE CROSS-REFERENCE TO THE APPROPRIATE ComPLETION When asked where the call light was, R55 stated, ""When asked where the call light is." Surveyor notified fait and and st 1:17 p.m., NAR-B verified RS55's call light was on the floor, under the bed and not in reach or view for R55's bed. F 246 On 7/17/14, at 2:44 a.m., RN-A stated that a belt will be set beside R55 the d. Chor 7/17/14, at 2:44 a.m., RN-A stated that a belt will be set beside R55 the d. Mont State Decomptional therapy stated R55 dated floor stated or view for R55's bed. Chor 7/17/14, at 2:44 a.m., RN-A stated that a belt will be set beside R55 the R55 the d. During the environmental lour on 7/17/14, at 1:111 p.m., R55 werbalized being able to use the bell. During the environmental lour on 7/17/14, at 1:111 p.m., R55's call light was observed oiting on top of R55's reach to safely access instead of the call light "Image" access inst			24522	4	B. WING	I		0	7/17/201/	۲.
Additional Provided Proceedings HASTINGS HASTINGS, MN 55033 (X4) ID Preferx SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEEDED BY FUL RESULATORY OR USD DEFICIENCY TAG ID PROVIDENE PLAN OF CORRECTION (EACH DEFICIENCY) ID PROVIDENE PLAN OF CORRECTION (EACH DEFICIENCY) Oran Deficiency Oran Oran Deficiency Oran D	NAME OF F	PROVIDER OR SUPPLIER	**************************************			ST	REET ADDRESS, CITY, STATE, ZIP	CODE	/////////-	<u> </u>
Prefex TAG (EAOI CONTICTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) PREFX TAG (EAOI CONTICTIVE ACTION SHOULD BE DEFICIENCY) CONTINUEST BE PRECEDED BY FULL TAG F 246 Continued From page 12 p.m., R55 was observed sitting on top of bed with with 3-4 feet away from bed, facing away from bed. R55 was attempting to grasp the with handles, and said, "I want to get into my chair." When asked where the call light was, R55 stated, "I don't know where my call light is." Surveyor notified staff and and at 1:17 p.m., NAR-B settified R55's call light was on the floor, let me cipit ts oit docent'tall. On the clip is broke". NAR-B stated 'It must have failen to the floor, let me clip it so it docent'tall. On the clip is broke". NAR-B stated 'It must have failen to the floor, R55's bed. On 7/17/14, at 8:44 a.m., RN-A stated that a bell will be set beside R55's a.m., RN-A stated that a bell will be set beside R55's failing in the hall so that R55 could cocess it then she needed help from staff. RN-A also stated occupational therapy would be doing an assessment for R55's ability to use the bell. At 2:58 a.m., RN-A stated cocupational therapy stated R55 did well with using the bell on a trial run. R55's call light was observed clipped on top of R55's call light was observed sitting in with hall near staff. R55's call light was observed clipped on top of R55's reach bardel access its with R55's reach to safely access instand of the call light lying on the floor under bed. On 7/16/14, at 2:35 p.m. RN-A stated to surveyor,	AUGUST	ANA HEALTH CARE	CENTER OF HAST	ïngs		1				
 p.m., R55 was observed sitting on top of bed with w/s 3-4 feet away from bed, facing away from bed. R55 was attempting to grasp the w/c handles, and said, "I want to get into my chair." When asked where the call light was, R55 stated, "I don't know where my call light is "Surveyor notified staff and and at 1:17 p.m., NAR-B verified R55's call light was on the floor, under the bed and not in reach or view for R55. NAR-B stated 'It must have fallen to the floor, I the edp it so it doesn't fall. Oh the clip is broke". NAR-B stated 'It must have fallen to the floor, I the edp it so it doesn't fall. Oh the clip is broke". NAR-B stated 'It must have fallen to the port of R55's call light was observed clipped on the top of R55's bed. On 7/17/14, at 8:44 a.m., RN-A stated that a bell will be set beside R55 down assisted R55's ability to use the bell. At 9:55 a did will with using the bell on a triat nur. R55 verbalized being able to use the bell. During the environmental tour on 7/17/14, at 1:11 p.m., R55 was observed sitting in w/c in hall near staff. R55's call light with using the bell. During the environmental tour on 7/17/14, at 1:11 p.m., R55 was observed oblipped on top of 7/15's call light with using the bell. During the environmental tour on 7/17/14, at 1:11 p.m., R55 was observed sitting in w/c in hall near staff. R55's call light was observed oblipped on top of R55's call light was observed oblepad not point of the call light ying on the floor under bed. On 7/16/14, at 2:35 p.m. RN-A stated to surveyor, the floor state of the call light the state of the call light ying on the floor under bed. 	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED	BY FULL	PREF		(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	N SHOULD BE E APPROPRIATE	COMPLE	TION
"I will follow up on the call lights and do some education" in this unit. On 7/17/14, at 8:44 a.m., RN-A stated she had done a call light audit on the unit for call light FORM CMS-2567(02-99) Previous Versions Obsolete Event ID:9H7F11 Facility ID: 00877 If continuation sheet Page 13 of		p.m., R55 was obs w/c 3-4 feet away f bed. R55 was atter handles, and said, When asked where "I don't know where notified staff and a R55's call light was and not in reach or must have fallen to doesn't fall. Oh the R55 to w/c and sta clip and fix it. At 1 observed clipped of On 7/17/14, at 8:44 will be set beside I that R55 could acc from staff. RN-A therapy would be of ability to use the be occupational thera using the bell on a able to use the bell During the environ p.m., R55 was obs staff. R55's call lig of R55's bed. The light should be set reach to safely acc lying on the floor u On 7/16/14, at 2:3 "I will follow up on education" in this On 7/17/14, at 8:4 done a call light an	erved sitting on to rom bed, facing a mpting to grasp th "I want to get into e the call light was e my call light was e my call light is." a on the floor, let me e clip is broke". NA ted she would go (30 p.m., R55's ca on the top of R55's 4 a.m., RN-A state R55 when sitting in cess it when she r also stated occup doing an assessm eli. At 9:58 a.m., py stated R55 did, trial run. R55 ver il. mental four on 7/ served sitting in w ht was observed of administrator verl cured to bed and w cess instead of the inder bed. 5 p.m. RN-A state the call lights and unit. 4 a.m., RN-A state unit.	way from e w/c my chair." s, R55 stated, Surveyor IAR-B verified er the bed R-B stated "It clip it so it AR-B assisted get a new all light was is bed, ed that a bell in the hail so needed help ational ent for R55's RN-A said well with balized being 17/14, at 1:11 /c in hall near clipped on top fied R55's call within R55's e call light ed to surveyor, I do some ed she had c call light			·			

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TATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-0391
			A. BUILC	NG_		GOIVI	PLETED
		245224	B. WING			07/	17/2014
		CENTER OF HASTINGS			REET ADDRESS, CITY, STATE, ZIP CODE 30 WEST 16TH STREET		
				H	ASTINGS, MN 55033		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 246	Continued From p placement, some s and aldes sheets t	staff education, and careplan	F	246			
F 247 SS=D	System, Revision have a means of c assistance at all the procedural step nu so it is accessible Secure the call light resident. 483.15(e)(2) RIGH ROOM/ROOMMA A resident has the	right to receive notice before	7	247	Residents 44 and 95 have adjuste new roommate assignments. Residents, and/or, their represent	ative will	8/12/201
	changed. This REQUIREME by: Based on intervie facility did not ens representatives re- roommate change who had a roomm Findings include: R44 and R95 reconstruction R44 was interview when asked about recently, replied s When R44 was a given notice about	eived new roommates and no			be notified prior to receiving a net mate. This notification will be constrained in dent's EMR. Both social workers were re-inset the regulation and policy regardit mate notification on 7/31/2014. staff and facility management tea inserviced on roommate notificat quirements between 8/5/2014 an 8/9/2014. The room change notification (internal document) utilized as a for room changes has been revier modified to include notification roommates. Licensed staff and fi management will ensure notification new roommates occur during the NOCs/weekends.	onducted the resi- rviced on ng room- Licensed om were don re- d ce checklist wed and of new acility tion of evening/	

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245224	B. WING			07/	17/2014
	SUMMARY ST (EACH DEFICIENC	CENTER OF HASTINGS ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	93 H.	TREET ADDRESS, CITY, STATE, ZIP CODE 80 WEST 16TH STREET ASTINGS, MN 55033 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 247	7/15/14, at 11:50 a new roommate FM new roommate Ab asked whether giv FM-A did not recal When interviewed social worker (SW roommates recent to find documenta given notice of a r was also unable to of a roommate ch SW-A agreed all r The policy and pro Resident Rooms, resident or the de	ber (FM)-A was interviewed on .m. and when asked about a A-A indicated R95 received a out six months ago. When en a notice about the move Il being given notice. on 7/17/14, at 9:40 a.m. the C)-A indicated R44 had several tily due to death but was unable ation to indicate R44 had been bew roommate. For R95, SW-A o find any indication that notice ange had been given to FM-A. esidents should be given notice, becedure titled Transfers: dated 7/14, indicated the signated responsible person will ng seven days prior to the in		47	The Administrator will audit the l all resident's receiving new room to ensure proper notification was pleted. The Administrator is resp for ensuring that residents are not a new roommate. Issues with roo notification will be referred to the ity's QAPI meeting for input/sug from the Team.	mates com- onsible ified of ommate e facil-	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1 ' '	ING 01 - MAIN BUILDING 01	(X3) DAT	0938-0391 E SURVEY IPLETED
		245224	B. WING		07/	15/2014
	PROVIDER OR SUPPLIER	CENTER OF HASTINGS		STREET ADDRESS, CITY, STATE, ZIP CODE 930 WEST 16TH STREET HASTINGS, MN 55033		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) Completion Date
K 000	INITIAL COMMENT	TŞ	ко	00		
	FIRE SAFETY			n n h		
-26-14	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.		POC of 18 8-11-14		
Sign &	ON-SITE REVISIT CONDUCTED TO Y SUBSTANTIAL CO REGULATIONS HA	F AN AGCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE IS BEEN ATTAINED IN TH YOUR VERIFICATION.				
サイーレイー い	Minnesota Departm Fire Marshal Divisio Augustana Health C found not in substat requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National F	at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association D1, Life Safety Code (LSC),		RECEIVE		
ENT.	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-TAGS) TO:	THE PLAN OF R THE FIRE SAFETY		AllG - 8 2014		
1	Health Care Fire In: State Fire Marshal			MN DEPT. OF PUBLIC SAF STATE FIRE MARSHAL DIVI	SION	
ABORATOR	PIRICICAL OF PROVID	ERVSUPPLIER REPRESENTATIVES STOR	MATURE	1/2 IIdon wich	a de /	(XG) DATE

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 delictencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CM5-2557(02-99) Previous Versions Obsointe

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/29/2014 FORM APPROVED

GENTER	AS FOR MEDICARE	& MEDICAID SE	ERVICES			0	MB NO.	0938-0391
STATEMENT AND PLAN O	OF DEFICIENCIES	(X1) PROVIDER/SUP IDENTIFICATION	PLIER/CLW NUMBER:		E CONSTRUCTION 01 - MAIN BUILDING 01		(X3) DATE COMP	SURVEY PLETED
		2452	24	8. WING			07/1	5/2014
NAME OF F	PROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP	CODE		
AUGUST	ANA HEALTH CARE	CENTER OF HAS	nngs		30 WEST 16TH STREET ASTINGS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIEL Y MUST BE PRECEDE SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD	BE	(XG) COMPLETION DATE
K 000	Continued From pa 445 Minnesota St., St Paul, MN 55101 By email to: Marian THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO 1. A description of a to correct the defici 2. The actual, or pr 3. The name and/o responsible for com prevent a reoccurre Augustana Health 2-story building wit building was const original building wat determined to be o 1973, and 1992 ar to the building that II(111)construction. and the addition(s) allowed for existing surveyed as one building surveyed as one building	Sulte 145 -5145, or Whitney@state. RRECTION FOR TINCLUDE ALL DRMATION: what has been, of iency. oposed, completi rection and monit ence of the perso rection and monit ence of the deficient Care Center of H h a partial basem ructed at 3 different is constructed in f Type II(111) con a addition(s) was was determined to Because the only meet the constru- to buildings, the family of the family of the family of the meet the constru-	EACH OF THE r will be, done on date. on oning to ency. astings is a ent. The ent times. The 1967 and was istruction. In constructed to be of Type ginal building iction type	K 000		J		
	The building is fully fire alarm system v detection and space monitored for autor notification.	with full corridor su cos open to the co	moke orridor, that is					
FORM CMS-2	The facility has a liv 567(02-98) Previous Version		of 92 beds Event ID:9H7F2	í Pac	ulity ID: 00877	li continu	ation shee	t Page 2 of 6

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

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VENTER	IS FUR MEDICARE	& MEDICAID SERVICES		_	the second se	IVID INC.	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION 1 - MAIN BUILDING ()1		E ŞURVEY Pleted
		245224	B. WING			07/1	15/2014
	ANA HEALTH CARE	CENTER OF HASTINGS		93	REET ADDRESS, CITY, STATE, ZIP CODE) WEST 16TH STREET ASTINGS, MN 55033		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IÚ PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO) DEFICIENCY)	DBE	(25) COMPLETION DATE
K 000 K 029 SS-D	The requirement at NOT MET as evide NFPA 101 LIFE SA One hour fire rated fire-rated doors) or extinguishing syste	of 74 at the time of the survey. 42 CFR Subpart 483.70(a) is enced by: FETY CODE STANDARD construction (with % hour an approved automatic fire m in accordance with 8.4.1	K	000			
	the approved autor option is used, the other spaces by sn doors. Doors are s field-applied protect	tects hazardous areas. When natic fire extinguishing system areas are separated from noke resisting partitions and self-closing and non-rated or tive plates that do not exceed bottom of the door are 2.1	n of the second s		5		
	Based on observa facility failed to ma partitions and door following requirem	is not met as evidenced by: tion and staff interview, the intain smoke-resisting s in accordance with the ents of 2000 NFPA 101, The deficient practice could residents.					
	on 07/15/2014, ob following was foun 1. 1st floor - Mainte	ween 8:15 AM and 11:15 AM servation revealed that the d: enance Shop - open st wall around 4 inch pipe				v	

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

Event ID;9H7F21

Feclity ID: 00877

If continuation sheet Page 3 of 6

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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ULIVILI	10 TON MEDIOMIL	& MEDICAID SERVICES			0	WID INU.	0938-0391
	OF DEFICIENCIES F CORRECTION	IX1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION D1 - MAIN BUILDING 01		L SURVEY PLETED
		245224	8. WING	-		07/1	15/2014
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA HEALTH CARE	CENTER OF HASTINGS			80 WEST 16TH STREET ASTINGS, MN 55033		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(XS) COMPLETION DATE
K 029	2. 1st floor - Boiler i south wall around 2 3. 1st floor - Activiti ft.) open penetratio around cables and 4. 1st floor - Storag across from room #	room - open penetrations on R inch pipe es storage room (over 50 sq. ns on south and west walls - pipes e room - (over 50 sq. ft.) #107, will not shut and latch echanical room - open	KI	029	The noted penetrations have all beer resealed with fire-caulk. Administrator and Maintenance Dir complete a monthly facility tour to evaluate and assess compliance with smoke barrier penetrations. The Maintenance Director is respon for ensuring compliance with smoke barrier penetrations.	rector h hsible	8/21/ 2014
K 071 SS=F	Facility Maintenance discovery, NFPA 101 LIFE SA Rubbish Chutes, In Chutes: (1) Any existing line pneumatic rubbish directly onto any co construction to pre- with a fire door ass rating of 1 hour. All section 9.5. (2) Any rubbish chu pneumatic rubbish with automatic extl accordance with 9. (3) Any trash chute collection room use protected in accord (4) Existing flue-fee	discharges into a trash ed for no other purpose and		071	The parts for the laundry chute latel are on order Administrator and Maintenance Dir complete a monthly facility tour and check the laundry chutes for proper sure. Additionally, staff were inser between 8/5/2014 and 8/9/2014 on forming Maintenance if/when there issues with proper closure. The Maintenance Director is respon for ensuring that the laundry chutes properly.	ector d will clo- viced in- are usible	8/20/2014

Facility ID: 00877

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

16

PRINTED: 07/29/2014 FORM APPROVED OMB NO: 0938-0391

					10 140. 0000-0001
	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
2.00-20-00-000		245224	B. WING		07/15/2014
	PROVIDER OR SUPPLIER ANA HEALTH CARE	CENTER OF HASTINGS	9:	TREET ADDRESS, CITY, STATE, ZIP CODE 30 WEST 16TH STREET IASTINGS, MN 55033	
(X4) ID PREFIX TAG	(EAGH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPS DEFICIENCY)	BE COMPLETION
K 071	Continued From pa 19.5.4, 9.5, 8.4, NF	-	K 071		e e
	This STANDARD i Based on observat chute that does not Sections 19.5.4, 9. deficient practice c Finding Include: On facility tour betw on 07/15/2014, obs and 2nd floor solled latch. These deficient pra Facility Maintenand	Is not met as evidenced by: is not met as evidenced by: ions, the facility has a laundry t meet the requirements of 5 and 8.4 and NFPA 82. This ould affect 74 residents ween 8:15 AM and 11:15 AM servation revealed, that the 1st d linen chute doors do not actices were confirmed by the se Director (KV) at the time of			
K 144 SS∋F	Generators are ins	FETY CODE STANDARD pected weekly and exercised ninutes per month in FPA 99. 3.4.4,1.	K 144	The generator service contractor (Cummins NPOWER) is scheduled come to the facility on 8/20/2014 to complete the 2 hour load bank test. Maintenance Director spoke with th company on 7/12/2014 regarding th failure to comply with regulations. Maintenance Director is responsible ensuring that the company complie the regulations regarding the load b test.	ne neir e for s with
	This STANDARD	Is not met as evidenced by:			
FORM CMS-2	567(02-99) Previous Varsion	s Obsolate Evant ID:9H7F2	1 F a	nality 10: 00877 li continu	lation sheel Page 5 of 6

	T OF DEFICIENCIES	E & MEDICAID SERVICES	(X2) MULTIPL	ECONSTRUCTION	OMB NO (X3) DAT	E SURVEY
NU PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01 - MAIN BUILDING 01	CON	PLETED
		245224	8. WING		07/	15/2014
	PROVIDER OR SUPPLIEF			TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	TANA HEALTH CARE	CENTER OF HASTINGS		30 WEST 16TH STREET IASTINGS, MN 55033		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES 37 MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	IVLD BE	(X6) COMPLETION DATE
K 144	interview, the facili generators in acco of 2000 NFPA 101 6-4.2 (a) & (b) and could affect all 74 Findings Include: On facility tour bet on 07/15/2014, do annual 2 hour load dated 08/22/2013, generator was not first 30 minutes - 2 and last 1 hour - 7 The report indicate First 30 minutes = next- 30 minutes = last 1 hour = 74.39 back was at 89.6%	entation review and staff ity failed to test the emergency ordance with the requirements - 9.1.3 and 1999 NFPA 110 6-4.2.2. The deficient practice residents. ween 8:15 AM and 11:15 AM cumentation review of the t bank test from Cummins. of the diesel emergency run under the required loads (25%, next 30 minutes - 50%, 5%). ed the following: 24.6% = 49.7% %, 74.5% and when transferred	К 144			