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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 9TJM

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00353

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245238**
2.STATE VENDOR OR MEDICAID NO.
(L2) **739745302**

3. NAME AND ADDRESS OF FACILITY
(L3) **MAHNOMEN HEALTH CENTER**
(L4) **414 WEST JEFFERSON AVENUE, PO BOX 396**
(L5) **MAHNOMEN, MN** (L6) **56557**

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 **04/20/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **32** (L18)
13.Total Certified Beds **32** (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
	32			
(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 :
Gail Anderson, Unit Supervisor — 04/26/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 05/27/2016 (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
08/04/1981
(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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/14/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245238

May 27, 2016

Mr. Dale Kruger, Administrator
Mahnomen Health Center
414 West Jefferson Avenue, PO Box 396
Mahnomen, Minnesota 56557

Dear Mr. Kruger:

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 April 8, 2016 the above facility is certified for:

42 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 42 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.

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

Sincerely,

Mark Meath

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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 26, 2016

Mr. Dale Kruger, Administrator
Mahnomen Health Center
414 West Jefferson Avenue, PO Box 396
Mahnomen, Minnesota 56557

RE: Project Number S5238026

Dear Mr. Kruger:

On March 15, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 3, 2016. 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 April 20, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 28, 2016 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 March 3, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 8, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 3, 2016, effective April 8, 2016 and therefore remedies outlined in our letter to you dated March 15, 2016, 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.

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

Sincerely,

Mark Meath

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245238 Y1	A. Building B. Wing Y2	4/20/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0164	Correction	ID Prefix F0167	Correction	ID Prefix F0282	Correction
Reg. # 483.10(e), 483.75(l)(4)	Completed	Reg. # 483.10(g)(1)	Completed	Reg. # 483.20(k)(3)(ii)	Completed
LSC	03/31/2016	LSC	04/08/2016	LSC	04/08/2016
ID Prefix F0312	Correction	ID Prefix F0431	Correction	ID Prefix F0441	Correction
Reg. # 483.25(a)(3)	Completed	Reg. # 483.60(b), (d), (e)	Completed	Reg. # 483.65	Completed
LSC	04/08/2016	LSC	03/31/2016	LSC	03/31/2016
ID Prefix F0465	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.70(h)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	03/23/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	GA/mm	04/26/2016	28034	04/20/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/3/2016

[ ] 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245238 Y1	A. Building 01 - 1969 BUILDING WITH 1975 ADDITION B. Wing Y2	3/28/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0062	03/23/2016	LSC K0067	03/23/2016	LSC K0144	03/23/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0147	03/23/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	TL/mm	04/26/2016	36536	03/28/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/1/2016

[ ] 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: 9TJM

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00353

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245238**

2.STATE VENDOR OR MEDICAID NO.
(L2) **739745302**

3. NAME AND ADDRESS OF FACILITY
(L3) **MAHNOMEN HEALTH CENTER**
(L4) **414 WEST JEFFERSON AVENUE, PO BOX 396**
(L5) **MAHNOMEN, MN** (L6) **56557**

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 **03/03/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **32** (L18)

13.Total Certified Beds **32** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	32			
(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 :
Denise Erickson, HFE NEII 04/01/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 04/06/2016 (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
08/04/1981
(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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 15, 2016

Mr. Dale Kruger, Administrator
Mahnomen Health Center
414 West Jefferson Avenue, PO Box 396
Mahnomen, Minnesota 56557

RE: Project Number S5238026

Dear Mr. Kruger:

On March 3, 2016, 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:

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

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

Remedies - 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;

Potential Consequences - 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:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140 Fax: (218) 332-5196

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 April 12, 2016, 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 April 12, 2016 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

been affected by the deficient practice;

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

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

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

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

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following 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 ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 June 3, 2016 (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 September 3, 2016 (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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic 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:

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

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

Sincerely,

Mark Meath

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164		3/31/16

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

Electronically Signed | 03/23/2016

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

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	245238	A. BUILDING _____ B. WING _____	03/03/2016

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F 164	Continued From page 1 The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to respect individual preferences and provide a dignified dining experience for 23 of 23 residents currently residing in the facility and having the option of eating meals in the dining room. Findings include: Observations included: On 2/29/16, at 5:21 p.m. R19 was seated at table in the dining room when licensed practical nurse (LPN)-A entered the dining room with medications which included eye drops. Administered oral medication, handed R19 a tissue and proceeded to administer ordered eye drop while R19 was seated at the dining room table eating her evening meal. Two additional non-interviewable residents R31 and R16 were seated at the table observing this process. On 3/1/16, at 11:30 a.m. R20 was seated at the dining room table eating her noon meal when LPN-C entered the dining room, informed R20 that she needed to check her blood sugar (BS) and give her insulin. R20 put down her fork, and reached out her hand to LPN-C, who applyed a lancet to R20's, obtained a blood sample and	F 164	F164 D Effective 03/07/16 Accu checks, insulin, eye drops and nasal spray will not be administered in the dining room or commons area and will be administered in a private area instead. The medication administration policy was revised to indicate this change. All nursing staff will be educated on the policy by 03/22/16 by the DON/Designee. The RN Coordinator will monitor compliance through weekly observations of medication administration. The data will be brought through the QAPI process until determined compliant	

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F 164	Continued From page 2	F 164		

utilized the glucose monitor to check her BS. LPN-C then raised R20's right sleeve and administered the ordered insulin dose via subcutaneous injection. Two additional residents R14 and unknown resident were seated at the table observing this process.

On 3/2/16, at 7:23 a.m. R9 was seated at a table in the dining room eating his breakfast when LPN-B entered the dining room, administered R9's oral medication and handed him a tissue and then administered ordered eye drops. A second resident R 18 was seated at this table observing this process.

On 3/2/16, at 7:33 a.m. R25 was seated at a long dining room table containing four additional residents, (R1, R3, R6, and R4) and eating breakfast when LPN-B entered the room, proceeded to R25, administered oral medication, informed R25 she had the nasal spray and also eye drops for her. LPN-B handed R25 a tissue and administered nasal spray to both nostrils, and then administered ordered eye drops. R1 was seated at the end of the table observing this process with an expression of distaste(wrinkled nose and frown).

On 3/1/16, at 11:45 a.m. LPN-C indicated eye drops, nasal sprays, injectable medications and blood glucose checks were routinely administered to residents in the dining room. LPN-C further stated she was not aware of any residents who objected to the practice, but had not asked. LPN-C stated this had been an ongoing practice in the facility.

During an interview on 3/2/16, at 7:45 a.m. LPN-B indicated eye drops, and nasal spray were

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normally administered in the dining room, unless a resident stated they did not want the medications given there.

The director of nursing (DON) was interviewed on 3/02/16, at 9:51 a.m. and indicated it was usual facility practice to check BS, administer insulin, eye drops and/or nasal sprays in the dining room. The DON indicated residents were asked upon admission if it is something that bothers them and they have the option of receiving medications in their room. The DON further stated residents were asked if there were any problems or things bothering them at resident council, but indicated the residents were not asked if seeing other residents receive injections, eye drops,or nasal sprays bothered them.

On 3/02/16, at 12:28 p.m. registered nurse (RN)-A was interviewed and indicated the facility routinely asked during the admission process if a resident was "OK" with receiving their medications in the dining room or if they preferred to receive it in a private location. RN-A stated this was reviewed again at quarterly care conferences. RN-A further stated the person receiving the medications was asked about receiving their medications, but she was not aware of any interviewing of tablemate's, or others able to view the procedure if it bothered them.

During interview on 3/03/16, at 8:20 a.m. R3 was asked about the facility practice of administering eye drops, nasal sprays, insulin and/or checking BS at the table and stated, "I don't think it is right to do that, doctor stuff at the table. "I don't like it." R3"s Brief Interview for Mental Status(BIMS), from the most recent assessment (quarterly)

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dated 11/27/15 indicated a score of 9/15 which indicated moderate cognitive impairment.

During an interview on 3/03/16, at 8:30 a.m. R 19 was asked if she saw other residents receiving eye drops, nasal spray, injections or BS checks in the dining room during meals and if this practice was acceptable to her. "I don't think it should be done in here" and further stated, " I think it should be done somewhere else." R19's BIMS,from the most recent assessment (annual) dated 1/14/16, was 3/15 which indicated severe cognitive impairment.

R14 was interviewed following the noon meal on 3/1/16, at 12:15 p.m. if observerving the administration of injections while he was eatting his meals bothered him and his reply was he was used to it. R14's BIMS from the most recent (quarterly) assessment dated 12/1/15, indicated a score of 12/15, which indicted moderate cognitive impairment.

On 3/3/16, at 3:00 p.m. R1 indicated she had watched other residents receive nasal sprays, eye drops or injections in the dining room for so long she was used to it. R1's most recent BIMS was 13/15, from the (quarterly) assessment dated 9/27/15. R1's cognition was indicated to be intact.

Review of the Policy: Medication and Treatment Administration Date, Reviewed/Revised: 10/30/15/ Medication Administration: Insulin is administered in the dining room after signing the Medication/Treatment Administration Authorization form upon admission and is noted in the care plan, unless the resident declines and requests to be administered privately.

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F 167 SS=D	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to post survey results in a manner that was readily accessible to all residents and visitors. This had the potential to affect all 23 residents residents residing in the facility and visitors to the facility. Findings include: During observation on 2/29/16, at 2:30 p.m. a sign was noted on the wall located to the left of the entrance doors. This sign read, "The MN Department of Health's current survey findings for Mahnomen Health Center's Nursing Home can be found at the Nursing Station." The survey results were observed hanging by a binder ring on the wall located behind the counter of a receptionist area, which was located on the opposite side of the hall. The receptionist counter, which was approximately 48-50 inches in height and 18 inches in width, contained a large green plant. The survey results were hanging behind the plant, unable to be reached by anyone	F 167	F 167 D 03/01/16 the survey results were moved to the front entrance to be easily and handicap accessible. A note was posted in the nursing home communication book 03/08/16 about the survey relocation. All facility staff will be educated by 03/29/2016 at the staff meetings and through meeting minutes for staff unable to attend. Residents will be informed in the daily newsletters of the change of location starting 04/02/2016 until the Resident council meeting and then residents will be informed at each resident council meeting of the location of the survey book. The staff/employee monthly newsletter for April, May and June will include the area where the survey book was relocated. Family council will be informed on the location of the survey book at the Family Council meeting scheduled for May 2016. The location of the survey book will be monitored by	4/8/16

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F 167	Continued From page 6 seated in a chair or cart at the reception counter. The height of the survey findings was confirmed by maintenance to be at a height of 52 inches above the floor. The desk side of the counter was able to be accessed through an open doorway, but would require a person to enter the area behind the receptionist's desk and navigate around the desk chair and two four-drawer file cabinets to reach the wall where the results were hanging. During an interview on 3/3/16 at 5:10 p.m. registered nurse (RN)-A verified a seated person would not likely be able to reach the posted survey results from the front on the receptionist desk and many persons would not enter an area that was behind a desk to retrieve the results. RN-A further stated a resident or visitor could ask about the results and a staff member would retrieve them.	F 167	DON/Designee monthly to ensure it is in the proper location and accessible to residents and visitors. The data will be brought through the QAPI process until determined compliant.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement the plan of care related to oral care for 1 of 2 residents (R11) who was dependent on staff for personal hygiene needs. Findings include:	F 282	F282 D All care plans were reviewed for accuracy by the MDS coordinator regarding assistance in ADL□s by 03/22/2016. A note was placed in the communication book on 03/07/16 reminding staff to follow care plans and to offer oral cares or	4/8/16

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F 282	Continued From page 7 R11's care plan dated 1/21/16 identified R11 had no teeth of his own and didn't want dentures. The care plan directed staff to set up R11 with swabs and mouthwash for morning and evening cares. On 3/02/16, 8:10 a.m. observations of assistance with personal cares by NA-A and NA-E for R11 was conducted. R11's was observed to have no natural teeth or dentures in his mouth with both upper and lower gums visible in his mouth when open. R11 was not offered nor set up with supplies needed to complete oral cares during the observation. On 3/02/16, at 9:08 a.m. NA-B and NA-D transferred R11 from his wheelchair to his bed after breakfast and immediately left the room. R7 was not offered nor set up with supplies to complete oral cares. NA-D stated R7 should receive oral care in the evening and when he gets up in the morning. She stated she felt R7 had top teeth but no bottom teeth or dentures. She stated she was unaware if R7 had received assistance to complete oral cares this morning. On 3/02/16, at 9:26 a.m. NA-A stated R7 was supposed to have oral care after breakfast. She stated she thought R7 had his own teeth on the top and bottom. She confirmed she had not assisted R7 to perform oral cares this am and had not offered assistance, and stated she felt oral cares should have been done by NA-B and NA-D before they laid R7 down after breakfast. On 3/02/16, at 9:35 a.m. NA-E stated she forgot to ask R7 if he wanted oral cares this morning and confirmed R7's oral cares weren't done this morning. She stated if he would refuse before	F 282	assistance with oral cares to all residents even if they continuously refuse. On 03/29/16 NARs will be provided education regarding providing ADL assistance, following resident care plans in POC, Oral Care policy and education regarding delivery of oral care. All education will be provided one on one to those unable to attend staff meeting by 04/08/2016. Oral cares will be randomly observed weekly starting 04/01/2016 for proper oral cares and then random oral competency checks will be performed by RN unit coordinator on a monthly basis to ensure that proper oral cares are being performed for all Residents. The data will be brought through the QAPI process until determined compliant.	

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F 282	Continued From page 8 breakfast, then he should be offered before staff assisted R7 to lie down after breakfast. On 3/02/16, at 9:36 a.m. NA-B confirmed she helped NA-D lie R7 down after breakfast and oral cares had not been offered or provided. She stated she wasn't sure if R7 received oral care before breakfast this morning. On 3/03/16, at 4:52 p.m. DON confirmed R11's care plan and stated she would expect staff to follow R11's care plan and provide oral care morning and night. Mouth Care policy dated 3/2013, indicated the facility would keep resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth, and to prevent infections of the mouth after review of resident's plan of care for special needs.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide oral care for 1 of 2 residents (R11) who was dependent on staff for assistance with personal hygiene needs. Findings include:	F 312	F312 D All care plans were reviewed for accuracy by the MDS coordinator regarding assistance in ADL□s by 03/22/2016. A note was placed in the communication book on 03/07/16 reminding staff to follow	4/8/16

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F 312	Continued From page 9 R11's quarterly Minimum Data Set (MDS) dated 1/1/16 identified R11 had diagnoses which included heart failure, diabetes mellitus and atrial fibrillation. The MDS identified R11 had severe cognitive impairment and was totally dependent on staff performance for personal hygiene needs, dressing and transfers. R11's care plan dated 1/21/16 identified R11 had no teeth of his own and did not want dentures. The care plan directed staff to set up R11 with swabs and mouthwash for morning and evening cares. On 3/02/16, 8:10 a.m. observations of assistance with personal cares by NA-A and NA-E for R11 was conducted. R11's was observed to have no natural teeth or dentures in his mouth with both upper and lower gums visible in his mouth when open. R11 was not offered nor set up with supplies needed to complete oral cares during the observation. On 3/02/16, at 9:08 a.m. NA-B and NA-D transferred R11 from his wheelchair to his bed after breakfast and immediately left the room. R7 was not offered nor set up with supplies to complete oral cares. NA-D stated R7 should receive oral care in the evening and when he gets up in the morning. She stated she felt R7 had top teeth but no bottom teeth or dentures. She stated she was unaware if R7 had received assistance to complete oral cares this morning. On 3/02/16, at 9:26 a.m. NA-A stated R7 was supposed to have oral care after breakfast. She stated she thought R7 had his own teeth on the top and bottom. She confirmed she had not	F 312	care plans and to offer oral cares or assistance with oral cares to all residents even if they continuously refuse. On 03/29/16 NARs will be provided education regarding providing ADL assistance, following resident care plans in POC, Oral Care policy and education regarding delivery of oral care. All education will be provided one on one to those unable to attend staff meeting by 04/08/2016. Oral cares will be randomly observed weekly starting 04/01/2016 for proper oral cares and then random oral competency checks will be performed by RN unit coordinator on a monthly basis to ensure that proper oral cares are being performed for all Residents. The data will be brought through the QAPI process until determined compliant.	

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F 312	Continued From page 10 assisted R7 to perform oral cares this am and had not offered assistance, and stated she felt oral cares should have been done by NA-B and NA-D before they laid R7 down after breakfast. On 3/02/16, at 9:35 a.m. NA-E stated she forgot to ask R7 if he wanted oral cares this morning and confirmed R7's oral cares weren't done this morning. She stated if he would refuse before breakfast, then he should be offered before staff assisted R7 to lie down after breakfast. On 3/02/16, at 9:36 a.m. NA-B confirmed she helped NA-D lie R7 down after breakfast and oral cares had not been offered or provided. She stated she wasn't sure if R7 received oral care before breakfast this morning. On 3/03/16, at 4:52 p.m. DON confirmed R11's care plan and stated she would expect staff to follow R11's care plan and provide oral care morning and night. Mouth Care policy dated 3/2013, indicated the facility would keep resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth, and to prevent infections of the mouth after review of resident's plan of care for special needs.	F 312		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all	F 431		3/31/16

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F 431	Continued From page 11 controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain labeled medications according to safe and acceptable standards of practice for 1 of 1 residents (R16) who received insulin after the documented end date of usage. Findings include:	F 431	F 431 D On 3/7/16 RN Unit Coordinator checked the Medication carts for outdated medications and disposed of any expired medications. RN staff will continue to check medication carts weekly and document findings. Charge nurses will be re-educated at the nurses meeting on March 22nd about expiration dates on	

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F 431	Continued From page 12 The North medication cart was observed on 3/1/16, at 11:14 a.m. with licensed practical nurse (LPN)-C in attendance and administering the ordered medications from this cart. R16's signed physician orders listed Lantus (insulin glargine) solution; 100 unit/milliliter (mL); 24 units subcutaneous once per day (QD) between 07:00 -10:00. The most recent date of administration from this multidose vial was documented as 07:00-10:00am on 3/1/16. The vial was dated with the date of expiration as 2/27/16. LPN-C confirmed R16's dose of insulin had been administered from this vial on 3/1/16 and doses for the dates of 2/28/16 and 2/29/16 would have also been administered from this vial. Review of the facility Pharmacy documentation indicated Lantus insulin had a date of expiration 28 days from the date it was opened. Review of the manufacturer's guidelines, titled Lantus (insulin glargine injection) solution for subcutaneous injection, dated 7/2015, identified in-use (opened) Lantus insulin had a expiration date of 28 days. During interview with the director of nursing on 3/1/16, at 11:30 a.m. it was verified the medications located in the medication cart were checked monthly for outdates and in addition, the nurse administering the medication would be expected to check dates on each vial prior to drawing up and administering the individual medication. Review of the facility policy Insulin Administration, revised 3/2013: Steps in the Procedure (Insulin Injections Via Syringe): Check expiration date, if drawing from an opened multi-dose vial. If opening a new vial, record expiration date and	F 431	insulin, eye drops and all other medications. Pharmacy consultant will do random medication cart checks for expired medications during site visit on a monthly basis. DON/designee will monitor medication carts for outdated medication monthly. The data will be brought through the QAPI process until determined compliant.	

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	245238	A. BUILDING _____ B. WING _____	03/03/2016

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F 431	Continued From page 13 time on the vial (follow manufacturer recommendations for expiration after opening).	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441		3/31/16

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F 441	Continued From page 14 infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the infection control surveillance program included ongoing tracking and analysis of infections to prevent the spread of infections in the facility. This deficient practice had the potential to affect all 23 of the 23 residents who resided in the facility. Findings include: The facility's Infection Control Logs were reviewed from September 2015, through March 2016. The logs identified tracked only residents with infections for which medication treatments were prescribed. The log lacked documentation of resident with symptoms of infections not treated with antibiotics. Furthermore, the facility lacked documentation of analysis and/or investigation of patterns identified. The facility utilized a form titled Infection Control Tracking-Resident; however, the resident infection was added to the form when a diagnoses of an infection and the prescription of an antibiotic or antifungal was received. The facility form titled Monthly Infection Report-Nursing Home, was completed monthly and tallied the infections diagnosed and treated into categories of urinary, cutaneous, upper respiratory, lower respiratory, gastrointestinal (GI), surgical wound infection, IV (intravenous)/blood stream and other. The documentation did not; however, provide analysis	F 441	F441 F On 3/21/16 the Infection Plan was reviewed by the DON, RN unit coordinator (NH infection control coordinator) and the facility infection control coordinator. A map of the NH, with resident rooms identified was developed to track locations. The monthly infection report for individuals form was newly developed to document information regarding infections among Residents in the nursing home in order to assist in tracking and trending. Lab will print a list of the infections that were identified per lab specimen results monthly and forward it to the NH staff. On 3/22/16 nursing staff will receive education regarding the infection prevention plan, tracking form, reporting residents with symptoms of infections on antibiotics and not on antibiotics and resident isolation. The RN unit coordinator will attend IDT meetings weekly to discuss residents who present with symptoms to assure resident infections are tracked and will report weekly to the facility infection control coordinator. The facility infection control coordinator will bring Infection Control data through the QAPI process monthly.	

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F 441	Continued From page 15 and/or investigation of patterns identified. On 3/03/2016, at 9:53 a.m. registered nurse (RN)-B verified she was responsible for the infection control program. RN-B indicated the following procedure for management of the infection control logs: a) after residents were prescribed a treatment for an infection the floor nurses completed green sheets with the resident information. b) the information from the green sheets were then placed onto the infection control log. c) the forms were reviewed for the number of infections and then reviewed at the Quality Assurance meeting. RN-B indicated the facility plan to have the monthly infection control logs reviewed and managed by second nurse had not started yet but would be. RN-B stated," I track the meds (medications) and symptoms." RN-B verified the current infection control program did not track infections not treated, the location in the building of the resident infection, or the organism of the infection. RN-B verified on 12/3/15, an antibiotic was changed because of the infection culture results; however, the culture results were not documented On 3/03/2016, at 5:02 p.m. The Director of Nursing (DON) indicated improvement with the infection control program/logs was planned. The DON stated we are in the process of setting up a program with a new employee." The facility policy titled Infection Prevention Plan dated 2015/2016, identified #4. Compliance with standards, regulations, and guidelines. Infection Prevention is responsible for ensuring that leadership is aware of the institution's compliance with all legal and accreditation standards as well	F 441		

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F 441	Continued From page 16 as with other evidence based guidelines and recommendations that pertain to the appropriate practice of infection Prevention.	F 441		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents' personal wheelchairs were maintained in good repair and sanitary manner for 1 of 3 residents (R12) observed to have a torn and soiled wheelchair arm. Findings include: Throughout the survey on 2/29/16, at 3:08 p.m. 3/1/16, at 2:40 p.m. 3/2/16, at 8:40 a.m., 1:20 p.m., and 2:22 p.m., R12's wheel chair arm rest on the right side had the entire front edge of the vinyl covering torn and missing, exposing two inches of the inside foam padding. The padding was yellowed, and stained with multiple darker yellow/brown spots the size of a pencil eraser. On 3/02/2016, at 1:20 p.m. the Maintenance director reviewed R12's right side wheel chair arm rest and verified the entire arm rest needed to be replaced. The maintenance director verified a repair request had not been made for R12's wheel chair arm rest.	F 465	F 465 D R12□s wheelchair arm was replaced with a new arm 03/02/16. On 03/18/16 maintenance did a check of all the equipment in the NH and fixed the equipment that needed repairs. Maintenance has developed a process for monthly equipment checks. Maintenance will check and maintain all equipment in the nursing home to ensure safety, functionality and sanitary compliance. The data will be brought through the QAPI process until determined compliant.	3/23/16

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F 465	Continued From page 17 Review of the duplicate house keeping/ maintenance repair/request notes at the nurses station on 3/02/2016, at 1:25 p.m. identified, no wheelchair repair request form had been completed for R12's wheelchair armrest. On 3/02/2016, at 2:22 p.m. the Director of Nursing (DON) verified R12's wheel chair arm rest needed to be repaired. The DON indicated notes at the nurses desk were to be completed when problems were identified and maintenance would managed the repair or would pass it on to the therapy department. The provided facility policy titled Medical Divide Reporting dated 5/2015, directed #2. The duplicate Maintenance Form will be completed by any member of staff to alert maintenance of a resident, patient or tenant-related equipment malfunction or loss of integrity.	F 465		

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Mahnomen Health Center (Nursing Home) 01 Building was found not in 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/23/2016

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

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K 000	Continued From page 1 responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Mahnomen Health Center (Nursing Home) was built at three different times. In 1969 the main building was added to the east of the Mahnomen Hospital. It is 1-story, without a basement and is Type II(111) construction. In 1996 an addition to the north of the kitchen was added, is 1-story, no basement and Type II (111) construction, In 2000, additions of 1-story, without basements and of Type II(000) construction were built to the west of the 1969 building and to the north of the 1996 building, The 1969 building is separated by a 2-hour fire barrier from the Hospital building and from the 2000 east addition. The facility has 3 smoke compartments separated by at least 30 minute fire barriers. The facility is protected with an automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition with quick response heads. The facility has a fire alarm system with corridor smoke detection, sleeping room smoke detection, and smoke detection in common areas in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. Automatic fire detectors are in all hazardous areas in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 32 beds and had a census of 23 at the time of the survey. Since the construction types of both buildings comply with the NFPA 101 "The Life Safety Code" and the facility is fully sprinkler protected, the facility was surveyed as a single building.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect all 23 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:15 am to 10:45 am on 03/01/2016 documentation review and staff interview revealed that there was no documentation for the inspection/calibration of the sprinkler system gauges within the last 5 years. This deficient practice was verified by the Facility Operations Manager	K 062	K 062 03/08/16 the gauge was replaced by Allied Fire Protection. The gauge will be monitored for the 5 year replacement/calibration by the facility director quarterly during the flow tests. Data will be brought to QAPI until determined compliant.	3/23/16
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed	K 067		3/23/16

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K 067	Continued From page 3 in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on documentation review it was revealed that the facility failed to provide proof of the fire damper testing in accordance with NFPA 101 (00) 9.3.1. This deficient practice could allow smoke to enter into another compartment causing the smoke barrier to be ineffective in a fire event and could negatively effect all 23 residents and an undetermined amount of staff and visitors. Findings Include: On the facility tour between 8:15 am to 10:45 am on 03/01/2016 documentation review and staff interview revealed that there was no documentation showing an inspection of the fire dampers within the last 4 years. The deficient practice was observed by the Facility Operations Manager.	K 067	K 067 03/17/16 dampers were all checked, closed properly, lubricated and checked that they were all in working order by the facility director. The facility director will continue to monitor and recheck within every four years per NFPA life safety code. This is documented on the fire damper log sheet.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on review of records and interview, the facility failed to maintain the emergency generator in accordance with the requirements of NFPA 110 - 1999 edition and NFPA 99 - 1999 edition, section 3-4.1.1.2. This deficient practice could affect the safety of all 23 residents and an undetermined amount of staff and visitors.	K 144	K 144 03/04/16 The emergency generator monthly test log sheet was revised to include a generator cool down period column to be included during the monthly generator checks. The facility director will monitor this through QAPI until determined compliant. See attachment.	3/23/16

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K 144	Continued From page 4 Findings include: On the facility tour between 8:15 am to 10:45 am on 03/01/2016 documentation review and staff interview revealed that there was no record of the generator cool down period. This deficient practice was verified by the Facility Operations Manager	K 144		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observations and an email recieved by the MDH surveryors it was revealed that the facility failed to maintain the facilitys electrical wiring per NFPA 101 (99) section 9.1.2 and NFPA 70. This deficient practice could affet 10 of the 23 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:15 am to 10:45 am on 03/01/2016 observation and staff interview revealed that an alcove in the North wing was used to store equipment which was blocking access to the electrical panels. This deficient practice was verified by the Facility Operations Manager	K 147	K 147 03/02/16 the therapy equipment was removed from the alcove in the north wing and a sign was placed in the alcove stating that no equipment is to be stored in that area. Facility director/designee will continue to monitor daily to ensure no equipment is being stored in that area.	3/23/16