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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: AG4J

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00343

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245228**
2.STATE VENDOR OR MEDICAID NO.
(L2) **019545601**

3. NAME AND ADDRESS OF FACILITY
(L3) **AVERA MORNINGSIDE HEIGHTS CARE CENTER**
(L4) **300 SOUTH BRUCE STREET**
(L5) **MARSHALL, MN** (L6) **56258**

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) **11/02/2009**

6. DATE OF SURVEY **04/02//2015** (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 **76** (L18)

13.Total Certified Beds **76** (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: * Code: **A** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	76			
(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 :
Kathryn Serie, Unit Supervisor 04/02/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 04/06/2015 (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
08/01/1979
(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
03/27/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245228

April 6, 2015

Ms. Mary Maertens, Administrator
Avera Morningside Heights Care Center
300 South Bruce Street
Marshall, Minnesota 56258

Dear Ms. Maertens:

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 March 18, 2015 the above facility is certified for.

76 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 76 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
April 2, 2015

Ms. Mary Maertens, Administrator
Avera Morningside Heights Care Center
300 South Bruce Street
Marshall, Minnesota 56258

RE: Project Number S5228025

Dear Ms. Maertens:

On February 24, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 6, 2015. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On April 2, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 23, 2015 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 February 6, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 18, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 6, 2015, effective March 18, 2015 and therefore remedies outlined in our letter to you dated February 24, 2015, 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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245228	A. Building B. Wing	4/2/2015

Name of Facility	Street Address, City, State, Zip Code
AVERA MORNINGSIDE HEIGHTS CARE CENTER	300 SOUTH BRUCE STREET MARSHALL, MN 56258

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0174** Reg. # **483.10(k),(l)** LSC	Correction Completed **03/18/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **03/18/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **03/18/2015**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **03/18/2015**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **03/18/2015**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **03/18/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/kfd	04/02/2015	03048	04/02/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 2/6/2015

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245228	02 - NEW BUILDING AND RENOVATED EXI	3/23/2015

Name of Facility	Street Address, City, State, Zip Code
AVERA MORNINGSIDE HEIGHTS CARE CENTER	300 SOUTH BRUCE STREET MARSHALL, MN 56258

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0143	02/06/2015	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	PS/kfd	04/02/2015	19251	03/23/2015
Reviewed By CMS RO				

Followup to Survey Completed on: 2/4/2015

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: AG4J

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00343

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245228**
2.STATE VENDOR OR MEDICAID NO.
(L2) **019545601**

3. NAME AND ADDRESS OF FACILITY
(L3) **AVERA MORNINGSIDE HEIGHTS CARE CENTER**
(L4) **300 SOUTH BRUCE STREET**
(L5) **MARSHALL, MN** (L6) **56258**

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) **11/02/2009**

6. DATE OF SURVEY **02/06/2015** (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 **76** (L18)

13.Total Certified Beds **76** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	76			
(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 :
Wendy Buckholz, HFE NE II 03/16/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/26/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1979
(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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
February 24, 2015

Ms. Mary Maertens, Administrator
Avera Morningside Heights Care Center
300 South Bruce Street
Marshall, Minnesota 56258

RE: Project Number S5228025

Dear Ms. Maertens:

On February 6, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

<u>Electronic 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;

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:

Kathryn Serie, Unit Supervisor
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Kathryn.serie@state.mn.us
Office: (507) 476-4233 Fax: (507) 537-7194

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 March 18, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

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

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));

- 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 May 6, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 6, 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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245228	A. BUILDING _____ B. WING _____	02/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTER	300 SOUTH BRUCE STREET MARSHALL, MN 56258

(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 174 SS=D	483.10(k),(l) RIGHT TO TELEPHONE ACCESS WITH PRIVACY §483.10(k) Telephone The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. §483.10(l) Personal Property The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate reports of missing personal property for 1 of 2 residents (R71) in the facility that was reviewed for personal property. Findings include:	F 174	1. Policy developed for Missing Items 2. Review policy on missing items and process for missing items will be reviewed with all staff at staff meeting on March 18, 2015 3. Staff will ask resident and/or family members if they have had any missing	3/18/15

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

Electronically Signed | 03/09/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245228	A. BUILDING _____ B. WING _____	02/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTER	300 SOUTH BRUCE STREET MARSHALL, MN 56258

(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 174	Continued From page 1 R71's family member (F)-A on 2/2/15, at 5:45 p.m. indicated R71 was missing a purple afghan/shawl that a ladies aide had given her. F-A stated he thought it was given to her when she had been sick, about a month ago. F-A further indicated he had reported the missing item to the facility staff but had received a response since. He stated, "I guess they just gave up on it." The social worker (SW) was interviewed on 2/5/15, at 10:00 a.m. She stated, "I don't know anything about that." She indicated the facility protocol for missing items was to complete a missing item report. The SW then implied that the report would go to the administrator, director of nursing (DON) and nursing aide supervisor. She further implied that one of the people would talk to the staff and look for the missing item. She stated that if an aide identified a missing item, they should talk to the registered nurse and then report to her or the director of nursing. She stated they would then follow up with the resident/family and if the item could not be found it would be replaced if possible. On 2/5/15, at 3:00 p.m. licensed practical nurse (LPN)-B and LPN-C were asked if they were aware of the missing afghan/shawl. LPN-B stated, "Oh no, no, I didn't hear anything about that." LPN-C hesitated and stated, "I'm not real sure....." On 2/5/15, at 4:33 p.m. nursing assistant (NA)-B stated she remembered the item going missing approximately a month ago. She stated it was a purplish afghan and stated "We [staff] looked all over for it" and she thought they were going to check the facility laundry but she never heard any	F 174	items at care conference times, and follow up if any reported. 4. Spread sheet will bedeveloped that will track missing items, report of missing items to LTC Quality Meeting monthly x 3 months, quarterly thereafter.	

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more about it. She stated she told the nurse about the afghan missing but could not recall which nurse it was.

On 2/5/15, at 4:30 p.m. R71's F-A arrived at the facility. F-A was asked which staff member he had told about the missing afghan/shawl. He stated, "I told everyone, the nurses, aides.... everyone." F-A was asked if he had told the social worker about the missing item. F-A stated, "Yup I did. I have it written down at home if you want me to get it." F-A stated that he was at the facility three times a day and he had told everyone and had not heard anything more about the missing afghan/shawl. F-A stated he figured it got thrown out as it was too soiled to wash since that was around the time his wife had the flu.

On 2/5/15, at 4:36 p.m. the nursing aide supervisor when asked about the missing afghan/shawl stated, "Well I don't recall that but you know he tells me so much stuff that it's hard to remember....."

On 2/6/15, at 9:20 a.m. the SW was informed R71's F-A had stated specifically he had told her about the missing afghan/shawl. She stated, "I don't recall. He is in here four to five times a day, I don't remember everything he says."

Review of the undated resident care policy regarding SAFEKEEPING noted, "The facility investigates all lost items, but is not financially responsible for lost or damaged items. The facility urges discretion in bringing valuable personal items." Although the facility was aware of the missing shawl, the facility did not assist R71 in retaining the misplaced clothing item.

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F 282	Continued From page 3	F 282		
F 282 SS=E	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 follow the written plan of care related to the identification of non-pressure related skin issue for 5 of 6 residents (R28, R62, R65, R123, R25) reviewed. Findings include: During observation on 2/5/15, at 11:47 a.m. it was noted R28 had three dark purple bruises located on the top of his left hand and one located on the top of his right hand. R28 and family (F)-B denied knowledge of how or when these bruises had occurred. Review of the care plan dated 7/2/14, listed the staff would check the skin in the morning and at bedtime for red, rashy or open areas or changes and report concerns to the nurses. The care plan did not include monitoring of bruising or other identified skin issues. The signed Physician Orders dated 12/16/14, indicated R28 received 81 milligrams (mg) Aspirin daily. The Minimum Data Set (MDS) dated 12/24/14, indicated R28 had severe cognitive impairment	F 282	1. Facility policy on skin care updated to reflect non-pressure related skin care and reporting. 2. Care plans for residents identified in survey updated to reflect current skin condition(s). 3. Review policy with staff at all staff meeting on March 18, 2015 4. On-going quality monitoring of compliance with policy/process will be completed and reported to LTC Quality Committee, monthly x 3 months, quarterly thereafter.	3/18/15

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F 282	Continued From page 4 and required extensive assistance with bed mobility, transfers, dressing, grooming, personal care, and ambulation. F-B was interviewed on 2/5/15, at 11:54 a.m. and stated R28 had fallen previously and she did not know if that could have caused the bruises or if they were from something else. Nursing assistant (NA)-A as interviewed on 2/5/15, at 12:09 p.m. and revealed she was not aware R28 had bruising on his hands. Licensed practical nurse (LPN)-C was interviewed on 2/5/15, at 12:56 p.m. and stated the procedure followed when bruising was identified was to notify the charge registered nurse (RN). The RN would then perform an assessment, and fill out the incident report if it was indicated. During a subsequent interview on 2/5/15, at 2:35 p.m. LPN-C stated she was not aware of bruising on R28's hands. LPN-C verified the bruises were present and should have been reported to the registered nurse (RN) for assessment. LPN-C measured the bruised areas. The bruise was located on R28's right hand was round and measured 1 centimeter (cm) long by (x) 1 cm wide. The bruise was located behind the knuckles of the 3rd and 4th digits. On R28's left hand-one bruise was 2.5 cm in long x 1.5 cm in wide. The bruise was located behind the knuckles of the 3rd and 4th digits and covered the area between the knuckles and wrist, the second bruise on the left hand measured 1.5 cm long x 1.5 cm wide. The bruise was located on the outer aspect of the wrist and extended onto the forearm. The third area was approximately dime sized and faded. The bruise was located behind the knuckle of the 1st digit and extended into the	F 282		

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F 282	Continued From page 5 area between the thumb and first digit. An interview was conducted with RN-A on 2/5/15, at 3:04 p.m. RN-A stated she was not aware of any bruising on R28's hands. She further stated staff was to notify the charge nurse regarding a resident bruise or other injury and the RN would then complete an assessment and update the doctor. Following observation of the bruised areas on R28's hands, RN-A verified that the areas should have been reported to the charge nurse, assessed and documented in the electronic record in addition to the physician being updated. The plan of care was not followed for R28 for reporting and monitoring of the current skin condition. R62 was observed seated in her wheel chair in her room on 2/2/15, at 4:45 p.m. A 1/2 inch dark purple bruise was observed on the top of her right arm. R62 could not recall where the bruise came from but stated "I probably just bumped it." The resident was also observed to have a red rashy area on the corners of her mouth and on her chin. On 2/5/15, at 9:19 a.m. R62 was sitting in the dining room. R62's chin continued to have a red rash on the corners of her mouth and on her chin. R62 was also observed to have a dark purple bruise just below the bruise noted on 2/2/15 on her right arm. R62 indicated at that time that she noticed the bruise yesterday but did not know how it occurred. The MDS dated 11/6/14, indicated R62 was severely cognitively impaired. Review of the care plan dated 11/20/14, identified a focus topic of skin conditions. Interventions listed; staff was required to be careful with positioning and transferring the resident due to the resident bruising easily; staff to check the resident's skin	F 282		

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in the a.m. and p.m. with cares and observe for any redness/rash or open areas. The staff should notify the charge nurse if concerns are identified.

Review of the skin assessment dated 2/3/15, identified a skin irregularity labeled "Rash Breast." but did not include the identified bruising or facial rash.

When interviewed on 2/4/15, at 2:29 p.m. household support staff (HSS)-A and trained medication aide (TMA)-A indicated they were unaware of the residents bruise on the right arm or skin rash. They both indicated if they had identified these skin issues they would notify the charge nurse.

When interviewed on 2/4/15, at 2:36 p.m. LPN-A indicated she was unaware of R62's bruise on her right arm nor did she notice the residents facial rash that a.m. when observed with cares. LPN-A indicated that all identified skin issues should be reported to the nurse.

On 2/05/2015, at 9:25 a.m. LPN-C confirmed R62's bruises on her right arm and facial rash. LPN-C indicated she had not observed the rash or bruises previously. LPN-C further included that an incident report should have been completed for any identified bruising and reported to the RN. She also stated the NA should have identified these skin issues with cares and report to the charge nurse.

When interviewed on 2/5/15, at 9:30 a.m. RN-A indicated there had not been an incident report or investigation completed for R62 bruising. RN-A further confirmed she was unable to obtain any documentation related to the residents bruise on

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F 282	Continued From page 7 her right arm or facial rash. R65 was observed seated in her room in her recliner on 2/2/15, at 5:28 p.m. The resident was observed to have an approximate 1.0 centimeter purple/red bruise on the top of her right elbow. R65 stated the bruise occurred during the night from bumping the grab bar. She denied anyone hurting her. The care plan dated 10/30/14, included skin conditions with interventions including, staff to check skin every a.m. and p.m. for any signs of redness/rash or skin breakdown and report any concerns to the licensed nurse. Review of the medical record did not identify the bruising. R65's MDS dated 1/26/15, indicated R65 to be moderately cognitively impaired. When interviewed on 2/5/15, at 9:57 a.m. RN-A stated she was unaware of the residents bruise. RN-A verified staff had not identified the bruise on R65's arm. R123 was observed seated in his recliner in his room with purplish bruising noted on the top of his left hand and top of his right hand extending to the wrist on 2/3/15, at 12:20 p.m. R123 could not identify how the bruising had occurred, but indicated it may have been during his recent hospital stay from a intravenous site. Review of R123's short term care plan dated 1/30/15, indicated the resident was admitted to the facility on 1/30/15. The care plan included a focus topic of skin conditions. Interventions included; staff will observe for bleeding/bruising.	F 282		

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F 282	Continued From page 8 Review of the admission skin assessment dated 1/30/15, identified R123 as having no skin irregularities with no bruising identified. No documentation in the residents medical record was found related to R123's bruising of the hands. When interviewed on 2/5/15, at 8:50 a.m. TMA-A indicated she had assisted R123 with morning cares, but did not notice bruising to the resident's right or left hand. TMA-A further included when she identifies a bruise she is to report it to the nurse. When interviewed on 2/5/15, at 8:41 a.m. LPN-D indicated she had not been aware of R123's bruising. LPN-D observed and verified R123's bruising to the top of the left hand and right hand. LPN-D further stated that inspection of the skin was to be completed twice daily when residents are gotten up in the morning and put to bed at night and that the bruises should have been identified and reported to the nurse. On 2/5/15, at 4:36 p.m. the director of nursing (DON) confirmed the large bruised area on the resident's right hand/wrist should have been addressed on the admission skin assessment if present or if the resident obtained the bruise after admission it should have been reported to the nurse and investigated at that time. When interviewed on 2/6/15, at 8:45 a.m. the facility administrator confirmed R123's bruising should have been identified and reported to the nurse and investigated/monitored.	F 282		

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R25 to have had a dark purple bruise between the knuckles of the 4th and 5th digits and a dark purple bruise on the lower forearm of the right extremity on 2/5/15, at 3:27 p.m.

R25's Admission Record dated 5/16/05, included diagnosis of cerebral vascular accident with right sided hemiparesis (paralysis). The MDS dated 11/27/14, indicated R25's cognition to be intact. The plan of care, last updated 12/4/14, indicated R25 was at risk for skin problems, skin tears and bruising easily due to immobility. Interventions included staff to observe skin for redness, rash and open areas in the morning and at bedtime. Staff were to provide cares slow, tell R25 what they were doing and to be careful with transfers. The record did not identify the bruises on the right hand and forearm.

During an observation and interview on 2/5/15, at 3:47 p.m. LPN-B measured the bruises and they were 1 centimeter (cm) diameter on the right forearm and 1.5 cm by 0.6 cm between the 4th and 5th digits on the right hand. RN-B was not aware of the bruises and did not find them identified in the medical record. RN-B reported that skin was checked with the bath.

During an interview on 2/5/15, at 3:41 p.m. the DON indicated that skin was to be observed with cares and concerns to be reported to the nurse. She indicated there was no formal weekly nurse skin assessment. The DON reported that she would expect the staff to be monitoring the skin and reporting changes to the charge nurse as per the care plan.

The policy titled, Pressure Ulcer Prevention Program Description, reviewed 4/14, included:

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F 282	Continued From page 10 B. Interventions (for prevention of pressure ulcers) 5. Monitoring - Expectations a. Daily inspection of skin condition is required. b. Report any changes in skin condition to supervising nurse.	F 282		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to identify and monitor skin issues for 6 of 6 residents (R28, R62, R65, R123, R5, R25) reviewed for non-pressure related skin conditions. Findings include: During an observation/interview on 2/2/15, at 5:15 p.m, R28 stated he didn't know how he had gotten the bruised areas on his hands. R28's spouse stated it might have been caused from R28 grabbing onto the stand up lift. She further stated she thought the bruises had been there for awhile and voiced concern about what had caused them.	F 309	1. Skin assessments completed on residents identified in survey. 2. Facility policy on Skin Care updated and reviewed with staff at all staff meeting on March 18, 2015. 3. On-going compliance will occur through quality monitoring of residents skin conditions. Monitoring will validate compliance with facility policy. Monitoring results will be reported to LTC Quality Committee monthly x 3 months, quarterly thereafter.	3/18/15

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During an observation on 02/05/15, at 11:47 a.m. it was noted that R28 had three (3) dark purple bruises located on the back of his left hand and one on the back of his right hand.

R28 was admitted on 6/25/14 with diagnoses including advanced dementia and heart disease. R28's quarterly minimum data set (MDS) dated 12/24/14 included a Brief Interview of Mental Status (BIMS) indicating severe cognitive impairment. The care plan dated 7/2/14 indicated skin condition would be monitored with morning and bedtime cares for red, rashy or open areas or changes and reported to the nurses.

When interviewed on 2/05/15, at 11:54 a.m. R28's spouse stated that R28 had fallen previously and she didn't know whether the fall had caused the bruises or what had happened. R28's spouse also stated she was not aware of any additional bruises or injuries that had occurred.

When interviewed on 02/05/15, at 12:09 p.m. nursing assistant (NA)-A stated she was not aware that R28 had bruising on the back of his hands.

When interviewed on 02/05/15, at 12:56 p.m. licensed practical nurse (LPN)-C stated the procedure followed when bruising was identified was to notify the charge registered nurse (RN). The RN would then perform an assessment, and fill out the incident report if it was indicated. During a subsequent interview on 2/5/15, at 2:35 p.m. LPN-C stated she was not aware of bruising on R28's hands. LPN-C verified the bruises were present and should have been reported to the RN for assessment. LPN-C measured the bruised

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areas. The bruise located on R28's right hand was round and measured 1 centimeter (cm) long by (x) 1 cm wide. The bruise was located behind the knuckles of the3rd and 4th digits. On R28's left hand-one bruise was 2.5 cm in long x 1.5 cm in wide. This bruise was located behind the knucles of the 3rd and 4th digits and covered the area between the knuckles and wrist , the second bruise on the left hand measured 1.5 cm long x 1.5 cm wide. This bruise was located on the outer aspect of the wrist and extended onto the forearm. The third area was approximately dime sized and faded. This bruise was located behind the knuckle of the 1st digit and extended into the area between the thumb and first digit.

When interviewed on 2/05/15, at 3:04 p.m. RN-A stated she was not previously aware of the bruising on R28's hands. RN-A verified the presence of the bruises and further indicated they should have been reported and assessed. RN-A further stated depending on the size and type of injury an incident report would be filed or it might be documented in the nursing progress notes without filing a report.

When interviewed on 2/5/15 at 3:40 p.m. the director of nursing (DON) stated that incident reports were not routinely completed for bruises. The DON further indicated if an area was small then a formal assessment was not necessary. In the instance of a large area or unknown cause then it would be monitored daily and the physician notified for orders on treatment.

On 2/2/15 at 4:45 p.m. R62 was observed seated in her wheel chair in her room. A 1/2 inch dark purple bruise was noted to the top of her right arm. R62 could not identify where the bruise

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came from but stated no one hurt her, "I probably just bumped it." Also noted that the corners of R62's mouth and her chin were very red and rashy. On 2/5/15, at 9:19 a.m. R62 was seated in the dining room and her chin continued to have a pink rash and the corners of her mouth were red and irritated (skin crease's around chin). Another dark purple bruise was noted and was located just below the one noted on 2/2/15 on her right arm. R62 stated she got that yesterday and did not know how it occurred.

The care plan dated 11/20/15 included skin conditions with interventions including: bruises easily and the bruises do not go away in a short time, staff need to be careful with positioning and transferring and the staff checks R62's skin a.m and HS [bedtime] for any redness/rash or open ares and notifies the licensed nurses of any concerns. Review of the medical record did not identify bruising or facial rash. The basic skin assessment dated 2/3/15 identified a skin irregularity labeled "Rash Breast."

When interviewed on 2/4/15, at 2:29 p.m. household support staff (HSS)-A and trained medication aide (TMA)-A stated if they discovered a new skin issue with a resident they would let the charge nurse know about it.

When interviewed on 2/4/15, at 2:36 p.m. LPN-A stated she had not seen any bruise and that this morning she didn't notice that R62's face was rashy. LPN-A stated she would check it later as R62 was in activities. She stated that if any new bruising or skin issue is found it should be reported to the nurse.

On 2/05/2015, 9:25 a.m. surveyor and LPN-C

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F 309	Continued From page 14 observed R62 in the dining room. LPN-C stated she had not seen the rash or bruises previously. She stated an incident report should be filled out for any bruising and reported to the registered nurse (RN). She also stated the aides are supposed to report any areas of bruising or skin problems to the nurse. When interviewed on 2/5/15 at 9:30 a.m. RN-A stated she didn't know of any incident reports being filled out about bruises on R62. She stated that maybe the LPN had filled one out. She stated either herself or the LPN were responsible to fill out the incident reports. RN-A was unable to find documentation of the skin issues in the medical record. On 2/2/15, at 5:28 p.m. R65 was observed seated in her room in her recliner. An approximate 1 centimeter purple/red bruise was noted on the top of R65's right elbow. R65 identified that the bruise occurred during the night from bumping the grab bar. She denied anyone hurting her. The care plan dated 10/30/14 included skin conditions with interventions including, staff check skin every am and HS for any signs of redness/rash or skin breakdown and will report any concerns to the licensed nurses. Review of the medical record did not identify the bruising. R65 receives 325 milligrams of aspirin everyday. When interviewed on 2/5/15, at 9:57 a.m. RN-A stated that she did not know about the bruise. She stated she did not know if anyone filled out an incident report on the bruise or not. She also verified that no one had identified the bruise on R65's arm.	F 309		

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During an observation on 2/6/15, at 8:11 a.m. noted R5's right hand to be dry, rough and cracked along the knuckle areas of all five fingers. R5 reported that she has had trouble with her hands all her life and sometimes they would bleed. R5 reported that she tries to put lotion on them daily.

R5's medical record indicated an admission date of 8/1/05 and diagnoses to include osteoporosis and history of pressure and stasis ulcers or sores. Documentation on the minimum data set (MDS) dated 12/3/14, indicated the brief interview for mental status (BIMS) of R5 identified moderate cognitive function. The plan of care (POC) last updated 6/16/14 indicated that R5 had a risk for skin breakdown due to peripheral vascular disease, diabetes, and also for pressure and stasis ulcer/sores. Interventions indicated that staff would check R5's legs, feet and heels daily for skin changes and notify the RN (registered nurse). The POC indicated that skin would be checked weekly at bath time and that they would notify the nurse if there were any concerns. The record did not identify the dry, rough and cracked condition of R5's right hand.

During an interview on 2/6/15, at 8:25 a.m. with the licensed practical nurse (LPN)- A indicated that there were no skin concerns with R5's hands. LPN-A inspected the right hand and verified that the skin was dry, rough and cracked and needed attention. LPN-A indicated the RN conducts skin assessments on admission, conduct weekly assessments on currently identified wound and skin conditions and staff were to report any changes to the nurse.

During an observation on 2/5/15, at 3:27 p.m.

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noted R25 had a dark purple bruise between the knuckles of the 4th and 5th digits on the right hand and a dark purple bruise on the lower forearm of the same extremity.

The medical record indicated that R25 had diagnoses which included cerebral vascular accident with right sided hemiparesis (paralysis). The MDS dated 11/27/14, the BIMS indicated cognition to be intact. The POC, last updated 12/4/14, indicated that R25 is at risk for skin problems, skin tears and bruised easily due to immobility. Interventions included staff to observe skin for redness, rash and open areas in the morning and at bedtime. Staff were to provide cares slow, tell R25 what they were doing and to be careful with transfers. The record did not identify the bruises on the right hand and forearm.

During an observation/ interview on 2/5/15, at 3:47 p.m. LPN-B verified R25's bruises measured 1 centimeter (cm) diameter on the right forearm and 1.5 cm by 0.6 cm between the 4th and 5th digits on the right hand. LPN-B was not aware of the bruises and did not find them identified in the medical record. LPN-B reported that R25's skin should have been checked weekly with the bath.

During an interview on 2/5/15, at 3:41 p.m. the director of nursing (DON) indicated that skin was to be observed with cares and any concerns reported to the nurse. She further indicated there was no formal weekly skin assessment conducted by the nurse. The DON reported that she would expect the staff to be monitoring the skin and reporting changes to the charge nurse.

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F 309	Continued From page 17 On 2/3/15, at 12:20 p.m. R123 was observed seated in his recliner in his room with purplish bruising noted to the top of his left hand and top of his right hand extending to the wrist. R123 could not identify how the bruising had occurred though stated it may have been while he was hospitalized. R123 further confirmed the bruising was not caused by abuse. R123 was admitted to the facility on 1/30/15 as identified on the short term care plan dated 1/30/15. The short term care plan included skin conditions with interventions including: staff will observe for bleeding/bruising. The skin assessment dated 1/30/15 indicated: no skin irregularities. When interviewed on 2/4/15, at 2:29 p.m. household support staff (HSS)-A and trained medication aide (TMA)-A stated if they discovered a new skin issue with a resident they would let the charge nurse know about it. When interviewed on 2/5/15, at 8:41 a.m. licensed practical nurse (LPN)-D stated when a new skin issue is identified the staff are to report it to the nurse. When reported to an LPN the LPN in turn will notify the registered nurse (RN) to complete the initial assessment. LPN-D reviewed R123's electronic record and could not find documentation that bruising had been identified. LPN-D then observed R123's bruising to the top of the left hand and right hand/wrist and confirmed it should have been reported. LPN-D indicated she would notify the RN to complete an assessment. LPN-D further stated that inspection of the skin is to be completed twice daily when residents are gotten up in the morning	F 309		

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F 309	Continued From page 18 and put to bed at night. LPN-D also confirmed that R123's bath day is on Tuesdays. When interviewed on 2/5/15, at 8:50 a.m. TMA-A confirmed she had assisted R123 with morning cares that day and did not notice bruising to the resident's right hand/wrist or top of left hand. TMA-A further stated that when she notices something out of the ordinary with a resident's skin she would notify the nurse. When interviewed on 2/5/15, at 3:40 p.m. the director of nursing (DON) stated a full body assessment is performed by the nurse upon admission. Direct care staff monitor skin with cares and also on bath day and will report changes to nursing if observed. DON stated with bruising an incident report is not completed unless it is a large area or if staff cannot determine how the bruising occurred. On 2/5/15, at 4:36 p.m. the surveyor and DON observed R123 lying on his back in his room. The DON confirmed the large bruised area on the resident's right hand/wrist should have been addressed on the admission skin assessment if present at time of admission or if new reported to the nurse and investigated. DON and surveyor viewed the purplish discoloring on R123's left hand. DON was questionable as whether the area was actually bruising or discoloring of the skin though confirmed it should have been noted on the admission skin assessment Review of the skin assessment dated 2/5/15 at 16:00 (4:00 p.m.) included: bruise right hand, old iv (intravenous) site, bruising 4 x (by) 3 (measurement was not identified as inches or centimeters), bruise left hand, 2.0 cm long x 2.0	F 309		

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F 309	Continued From page 19 cm wide, old iv site brown. When interviewed on 2/6/15, at 8:45 a.m. administrator confirmed that bruising should be reported to the nurse and investigated/monitored when identified. The policy titled, Pressure Ulcer Prevention Program Description, reviewed 4/14 included: B. Interventions (for prevention of pressure ulcers) 5. Monitoring - Expectations a. Daily inspection of skin condition is required. b. Report any changes in skin condition to supervising nurse.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 329		3/18/15

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F 329	Continued From page 20 contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to adequately monitor resident mood and behavior response following an increased antidepressant dose for 1 of 5 residents (R76) reviewed for unnecessary medications. Findings include: R76 was admitted to the facility on 6/16/14. Review of R76's history and physical by the physician dated 6/16/14 indicated medications that included sertraline (an antidepressant) 25 milligrams (mg) daily. Review of the physician orders dated 8/25/14, included an order to increase the sertraline dose from 25 mg daily to 50 mg daily. Review of the care plan dated 10/17/14 included: "I do not want to be sad or depressed. I want to maintain my memory and realize that it has declined. I have had depression in the past. Continue to give the medications per order. The staff will watch me for changes in my mood or indicators of depression. The social worker will do a depression screen quarterly." Review of the quarterly minimum data set (MDS) assessment dated 9/20/14 indicated that R76 had been assessed with a PHQ-9 (Resident Mood Interview) score of "0", indicating no depressive	F 329	1. Depression screen completed for identified resident. 2. Pharmacy review completed for identified resident. 3. Behavior monitoring for identified resident initiated upon completion of depression screen, started 3/5/15. 4. Facility policy on Response Guidelines to Resident Behavior in LTC updated and will be reviewed with staff at all staff meeting on 3/18/15. 5. Residents with orders for psychopharmacological medication will be discussed at resident's care conferences and discussion results forwarded to facility's Behavior Management Committee for evaluation. Any recommendations for drug order changes will be communicated to staff and behavior monitoring will be completed. Follow up review of behavior monitoring will continue at subsequent Behavior Management Committee meetings. 6. On-going compliance with behavior monitoring will be completed and reported to LTC Quality Committee monthly x 3, quarterly thereafter.	

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F 329	Continued From page 21 symptoms. The following and most recent MDS assessment dated 12/11/14 indicated a PHQ-9 score of "5", indicating mild depressive symptoms. Review of the electronic medical record indicated R76's mood and behavior was monitored from 6/17/14 - 6/22/14 with no identified mood and behaviors. The facility was unable to provide further evidence related to monitoring of R76's mood and behavior other than the quarterly MDS assessments. When interviewed on 2/05/2015, at 4:24 p.m. the director of nursing (DON) confirmed R76's mood and behavior had not been monitored following the increase of the antidepressant medication (sertraline) on 8/25/14. The facility pharmacist was not available for interview during the survey. Although the director of pharmacy services was interviewed on 2/06/2015, at 8:52 a.m. indicated he would expect staff to be monitoring mood and behavior with the increase of an antidepressant.	F 329		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate	F 425		3/18/15

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F 425	Continued From page 22 acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation interview and document review the facility failed to assure medications were available to residents in a timely manner for 1 of 1 resident (R65) who was observed during administration of eye drops. Findings include: During observation of the medication pass on 2/2/15, at 7:00 p.m. trained medication aide (TMA)-A was observed to set up medications for R65. The medication administration record (MAR) identified R65 was to receive Lantanoprost (to control the progression of glaucoma or ocular hypertension by reducing intraocular pressure) 0.005% eye drops, one drop to each eye. TMA-A removed a bottle of eye drops labeled Cosopt (used to treat glaucoma) from R65's medication cabinet. TMA-A looked at the bottle and compared it to the MAR. She stated, "Ya, this is it, it's the right one, it's the only one that is in there." At that point TMA-A was going to instill the Cosopt eye drops in to R65's eyes. The Surveyor stopped TMA-A from administering the incorrect medication. TMA-A then indicated she needed to	F 425	1. Facility policy on medication availability, expiration, storage updated and will be reviewed with LTC staff at all staff meeting on 3/18/15. 2. On-going compliance will be monitored through quality monitoring process. Results reported to LTC Quality Committee monthly x 3 months, quarterly thereafter.	

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F 425	Continued From page 23 check with the nurse. At 7:30 p.m. licensed practical nurse (LPN)-C was asked to come to R65's room. TMA-A explained that there were no Lantanoprost eye drops in R65's room. LPN-C checked the medication cabinet and confirmed R65 did not have any Lantanoprost eye drops in the cabinet. LPN-C indicated the Cosopt eye drops had been discontinued on 1/26/15, and did not know why there were no Lantanoprost eye drops available. Review of the medication records from 9/14/14 to 2/5/15, identified the facility staff were signing out the Lantanoprost drops as being either administered or refused. During interview with the director of nursing (DON) on 2/5/15, at 10:00 a.m. she brought a packing slip from the pharmacy dated 9/3/14. The packing slip identified that the facility received Latanoprost 0.005% drops for R65 on that date. The DON stated that was the last time the facility received the medication. She stated she did not know why the medication was not reordered. During interview with the consultant pharmacist on 2/6/15, at 9:15 a.m. he indicated the Latanoprost drops were good for 42 days after opening. He stated the Latanoprost bottle should be dated when opened and discarded 42 days after opening. He verified that the last bottle ordered was delivered on 9/3/14.	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 428		3/18/15

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F 428	Continued From page 24 The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review the pharmacist failed to identify the need for mood and behavior monitoring following an increased daily dose of an antidepressant for 1 of 5 residents (R76) reviewed for unnecessary medications. Findings include: R76 was admitted to the facility on 6/16/14. Review of R76's history and physical by the physician dated 6/16/14 indicated medications to include sertraline (an antidepressant) 25 milligrams (mg) daily. Review of the physician orders dated 8/25/14 included an order to increase sertraline to 50 mg daily. Review of the care plan dated 10/17/14 included: "I do not want to be sad or depressed. I want to maintain my memory and realize that it has declined. I have had depression in the past. Continue to give the medications per order. The staff will watch me for changes in my mood or indicators of depression. The social worker will do a depression screen quarterly." Review of the quarterly minimum data set (MDS) assessment dated 9/20/14 indicated a PHQ-9	F 428	1. Pharmacy review completed on identified resident. 2. Facility policy on Principles of Medication Use updated and reviewed with pharmacy staff and LTC staff at all staff meeting on March 18, 2015. 3. On-going compliance with drug regimen review will occur through quality monitoring activity. Results reported to LTC Quality Committee monthly x 3 months, quarterly thereafter.	

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F 428	Continued From page 25 (Resident Mood Interview) with a score of "0" indicating no depressive symptoms. The following and most recent MDS assessment dated 12/11/14 indicated a PHQ-9 score of "5" indicating mild depressive symptoms. Review of the electronic medical record indicated R76's mood and behavior was monitored from 6/17/14 - 6/22/14 with no mood and behaviors identified. The facility was unable to provide further evidence related to monitoring of R76's mood and behavior other than the quarterly MDS assessments. Review of the monthly pharmacy medication regimen reviews dated, 9/25/14, 10/25/14, 11/25/14, 12/26/14, and 1/26/15 did not identify the need for monitoring of mood and behavior related to the antidepressant use. When interviewed on 2/05/2015, at 4:24 p.m. the director of nursing (DON) confirmed monitoring of R76's mood and behavior had not been completed following the increase of the antidepressant medication (sertraline). The facility pharmacist was not available for interview during the survey. Although the director of pharmacy services was interviewed on 2/6/15, at 8:52 a.m. indicated he would expect staff to be monitoring mood and behavior with the increase of an antidepressant.	F 428		

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	245228	A. BUILDING **02 - NEW BUILDING AND RENOVATED EXISTING BLD** B. WING _____	**02/04/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTER	**300 SOUTH BRUCE STREET** **MARSHALL, MN 56258**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

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.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on February 4, 2015.. At the time of this survey, Avera Marshall Regional Medical Center Nursing Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies.

EPOC

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145
Facsimile: 651-215-0525, or

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/09/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245228	A. BUILDING **02 - NEW BUILDING AND RENOVATED EXISTING BLD** B. WING _____	**02/04/2015**

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K 000	Continued From page 1	K 000		

By e-mail to:
Marian.Whitney@state.mn.us and,
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 responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Avera Marshall Regional Medical Center Nursing Home was constructed as follows:
The original building was constructed in 1963, it is two-stories in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction;
The 2004 Addition is two-stories in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction.

The nursing home is separated from an attached hospital by 2-hour fire rated wall assemblies. The building has a fire alarm system with smoke detection in the corridors, which is monitored for automatic fire department notification. Additionally, all Resident Rooms are equipped with automatic smoke detection. The facility has a capacity of 76 beds and had a census of 70 at time of the survey.

Due to the extensive renovation of the original 1963 building, the entire facility was surveyed as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245228	A. BUILDING **02 - NEW BUILDING AND RENOVATED EXISTING BLD** B. WING _____	**02/04/2015**

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K 000	Continued From page 2 one building at NFPA 101 (2000) Chapter 18 New Health Care Occupancies. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 143 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility's liquid oxygen transferring room did not meet the requirements in accordance to NFPA 99(99)editon. Finding include; During facility tour between the hours of 9:00 AM. and 1:30 PM, on 02/04/2015, it was observed that the Liquid Oxygen Transferring Room did not have signage indicating that transferring is occurring, and that smoking is not permitted in accordance with NFPA 99 and the Compressed	K 143	Signage installed on the door of the Liquid Oxygen Transferring Room	2/6/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 143	Continued From page 3 Gas Association. This deficient practice was verified by the Maintenence Manager.	K 143		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
February 24, 2015

Ms. Mary Maertens, Administrator
Avera Morningside Heights Care Center
300 South Bruce Street
Marshall, Minnesota 56258

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5228025

Dear Ms. Maertens:

The above facility was surveyed on February 2, 2015 through February 6, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00343	A. BUILDING: _____ B. WING _____	02/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTE	300 SOUTH BRUCE STREET MARSHALL, MN 56258

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 2/2/15 - 2/6/15 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to follow the written plan of care related to the identification of non-pressure related skin issue for 5 of 6 residents (R28, R62, R65, R123, R25) reviewed. Findings include: During observation on 2/5/15, at 11:47 a.m. it was noted R28 had three dark purple bruises located on the top of his left hand and one located on the top of his right hand. R28 and family (F)-B denied knowledge of how or when these bruises had occurred. Review of the care plan dated 7/2/14, listed the staff would check the skin in the morning and at bedtime for red, rashy or open areas or changes and report concerns to the nurses. The care plan did not include monitoring of bruising or other identified skin issues.	2 565	Corrected	3/18/15

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2 565	Continued From page 3 The signed Physician Orders dated 12/16/14, indicated R28 received 81 milligrams (mg) Aspirin daily. The Minimum Data Set (MDS) dated 12/24/14, indicated R28 had severe cognitive impairment and required extensive assistance with bed mobility, transfers, dressing, grooming, personal care, and ambulation. F-B was interviewed on 2/5/15, at 11:54 a.m. and stated R28 had fallen previously and she did not know if that could have caused the bruises or if they were from something else. Nursing assistant (NA)-A as interviewed on 2/5/15, at 12:09 p.m. and revealed she was not aware R28 had bruising on his hands. Licensed practical nurse (LPN)-C was interviewed on 2/5/15, at 12:56 p.m. and stated the procedure followed when bruising was identified was to notify the charge registered nurse (RN). The RN would then perform an assessment, and fill out the incident report if it was indicated. During a subsequent interview on 2/5/15, at 2:35 p.m. LPN-C stated she was not aware of bruising on R28's hands. LPN-C verified the bruises were present and should have been reported to the registered nurse (RN) for assessment. LPN-C measured the bruised areas. The bruise was located on R28's right hand was round and measured 1 centimeter (cm) long by (x) 1 cm wide. The bruise was located behind the knuckles of the 3rd and 4th digits. On R28's left hand-one bruise was 2.5 cm in long x 1.5 cm in wide. The bruise was located behind the knuckles of the 3rd and 4th digits and covered the area between the knuckles and wrist, the second bruise on the left hand measured 1.5 cm long x	2 565		

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2 565	Continued From page 4 1.5 cm wide. The bruise was located on the outer aspect of the wrist and extended onto the forearm. The third area was approximately dime sized and faded. The bruise was located behind the knuckle of the 1st digit and extended into the area between the thumb and first digit. An interview was conducted with RN-A on 2/5/15, at 3:04 p.m. RN-A stated she was not aware of any bruising on R28's hands. She further stated staff was to notify the charge nurse regarding a resident bruise or other injury and the RN would then complete an assessment and update the doctor. Following observation of the bruised areas on R28's hands, RN-A verified that the areas should have been reported to the charge nurse, assessed and documented in the electronic record in addition to the physician being updated. The plan of care was not followed for R28 for reporting and monitoring of the current skin condition. R62 was observed seated in her wheel chair in her room on 2/2/15, at 4:45 p.m. A 1/2 inch dark purple bruise was observed on the top of her right arm. R62 could not recall where the bruise came from but stated "I probably just bumped it." The resident was also observed to have a red rashy area on the corners of her mouth and on her chin. On 2/5/15, at 9:19 a.m. R62 was sitting in the dining room. R62's chin continued to have a red rash on the corners of her mouth and on her chin. R62 was also observed to have a dark purple bruise just below the bruise noted on 2/2/15 on her right arm. R62 indicated at that time that she noticed the bruise yesterday but did not know how it occurred. The MDS dated 11/6/14, indicated R62 was	2 565		

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2 565	Continued From page 5 severely cognitively impaired. Review of the care plan dated 11/20/14, identified a focus topic of skin conditions. Interventions listed; staff was required to be careful with positioning and transferring the resident due to the resident bruising easily; staff to check the resident's skin in the a.m. and p.m. with cares and observe for any redness/rash or open areas. The staff should notify the charge nurse if concerns are identified. Review of the skin assessment dated 2/3/15, identified a skin irregularity labeled "Rash Breast." but did not include the identified bruising or facial rash. When interviewed on 2/4/15, at 2:29 p.m. household support staff (HSS)-A and trained medication aide (TMA)-A indicated they were unaware of the residents bruise on the right arm or skin rash. They both indicated if they had identified these skin issues they would notify the charge nurse. When interviewed on 2/4/15, at 2:36 p.m. LPN-A indicated she was unaware of R62's bruise on her right arm nor did she notice the residents facial rash that a.m. when observed with cares. LPN-A indicated that all identified skin issues should be reported to the nurse. On 2/05/2015, at 9:25 a.m. LPN-C confirmed R62's bruises on her right arm and facial rash. LPN-C indicated she had not observed the rash or bruises previously. LPN-C further included that an incident report should have been completed for any identified bruising and reported to the RN. She also stated the NA should have identified these skin issues with cares and report to the charge nurse.	2 565		

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2 565	Continued From page 6 When interviewed on 2/5/15, at 9:30 a.m. RN-A indicated there had not been an incident report or investigation completed for R62 bruising. RN-A further confirmed she was unable to obtain any documentation related to the residents bruise on her right arm or facial rash. R65 was observed seated in her room in her recliner on 2/2/15, at 5:28 p.m. The resident was observed to have an approximate 1.0 centimeter purple/red bruise on the top of her right elbow. R65 identified the bruise occurred during the night from bumping the grab bar. She denied anyone hurting her. The care plan dated 10/30/14, included skin conditions with interventions including, staff check skin every am and HS for any signs of redness/rash or skin breakdown and will report any concerns to the licensed nurses. Review of the medical record did not identify the bruising. The MDS dated 1/15/15, indicated R65 had moderate cognition impairment. When interviewed on 2/5/15, at 9:57 a.m. RN-A stated that she did not know about the bruise. She stated she did not know if anyone filled out an incident report on the bruise or not. She also verified that no one had identified the bruise on R65's arm. R123 was observed seated in his recliner in his room with purplish bruising noted on the top of his left hand and top of his right hand extending to the wrist on 2/3/15, at 12:20 p.m. R123 could not identify how the bruising had occurred, but indicated it may have been during his recent hospital stay from a intravenous site.	2 565		

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AVERA MORNINGSIDE HEIGHTS CARE CENTE	300 SOUTH BRUCE STREET MARSHALL, MN 56258

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2 565	Continued From page 7 Review of R123's short term care plan dated 1/30/15, indicated the resident was admitted to the facility on 1/30/15. The care plan included a focus topic of skin conditions. Interventions included; staff will observe for bleeding/bruising. Review of the admission skin assessment dated 1/30/15, identified R123 as having no skin irregularities with no bruising identified. No documentation in the residents medical record was found related to R123's bruising of the hands. When interviewed on 2/5/15, at 8:50 a.m. TMA-A indicated she had assisted R123 with morning cares, but did not notice bruising to the resident's right or left hand. TMA-A further included when she identifies a bruise she is to report it to the nurse. When interviewed on 2/5/15, at 8:41 a.m. LPN-D indicated she had not been aware of R123's bruising. LPN-D observed and verified R123's bruising to the top of the left hand and right hand. LPN-D further stated that inspection of the skin was to be completed twice daily when residents are gotten up in the morning and put to bed at night and that the bruises should have been identified and reported to the nurse. On 2/5/15, at 4:36 p.m. the director of nursing (DON) confirmed the large bruised area on the resident's right hand/wrist should have been addressed on the admission skin assessment if present or if the resident obtained the bruise after admission it should have been reported to the nurse and investigated at that time. When interviewed on 2/6/15, at 8:45 a.m. the	2 565		

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2 565	Continued From page 8 facility administrator confirmed R123's bruising should have been identified and reported to the nurse and investigated/monitored. R25 to have had a dark purple bruise between the knuckles of the 4th and 5th digits and a dark purple bruise on the lower forearm of the right extremity on 2/5/15, at 3:27 p.m. R25's Admission Record dated 5/16/05, included diagnosis of cerebral vascular accident with right sided hemiparesis (paralysis). The MDS dated 11/27/14, indicated R25's cognition to be intact. The plan of care, last updated 12/4/14, indicated R25 was at risk for skin problems, skin tears and bruising easily due to immobility. Interventions included staff to observe skin for redness, rash and open areas in the morning and at bedtime. Staff were to provide cares slow, tell R25 what they were doing and to be careful with transfers. The record did not identify the bruises on the right hand and forearm. During an observation and interview on 2/5/15, at 3:47 p.m. LPN-B measured the bruises and they were 1 centimeter (cm) diameter on the right forearm and 1.5 cm by 0.6 cm between the 4th and 5th digits on the right hand. RN-B was not aware of the bruises and did not find them identified in the medical record. RN-B reported that skin was checked with the bath. During an interview on 2/5/15, at 3:41 p.m. the DON indicated that skin was to be observed with cares and concerns to be reported to the nurse. She indicated there was no formal weekly nurse skin assessment. The DON reported that she would expect the staff to be monitoring the skin and reporting changes to the charge nurse as per the care plan.	2 565		

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2 565	Continued From page 9 The policy titled, Pressure Ulcer Prevention Program Description, reviewed 4/14, included: B. Interventions (for prevention of pressure ulcers) 5. Monitoring - Expectations a. Daily inspection of skin condition is required. b. Report any changes in skin condition to supervising nurse. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure the facility develops care plans according to the residents individualized needs. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		3/18/15

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2 830	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to identify and monitor skin issues for 6 of 6 residents (R28, R62, R65, R123, R5, R25) reviewed for non-pressure related skin conditions. Findings include: During an observation/interview on 2/2/15, at 5:15 p.m, R28 stated he didn't know how he had gotten the bruised areas on his hands. R28's spouse stated it might have been caused from R28 grabbing onto the stand up lift. She further stated she thought the bruises had been there for awhile and voiced concern about what had caused them. During an observation on 02/05/15, at 11:47 a.m. it was noted that R28 had three (3) dark purple bruises located on the back of his left hand and one on the back of his right hand. R28 was admitted on 6/25/14 with diagnoses including advanced dementia and heart disease. R28's quarterly minimum data set (MDS) dated 12/24/14 included a Brief Interview of Mental Status (BIMS) indicating severe cognitive impairment. The care plan dated 7/2/14 indicated skin condition would be monitored with morning and bedtime cares for red, rashy or open areas or changes and reported to the nurses. When interviewed on 2/05/15, at 11:54 a.m. R28's spouse stated that R28 had fallen	2 830	Corrected	

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2 830	Continued From page 11 previously and she didn't know whether the fall had caused the bruises or what had happened. R28's spouse also stated she was not aware of any additional bruises or injuries that had occurred. When interviewed on 02/05/15, at 12:09 p.m. nursing assistant (NA)-A stated she was not aware that R28 had bruising on the back of his hands. When interviewed on 02/05/15, at 12:56 p.m. licensed practical nurse (LPN)-C stated the procedure followed when bruising was identified was to notify the charge registered nurse (RN). The RN would then perform an assessment, and fill out the incident report if it was indicated. During a subsequent interview on 2/5/15, at 2:35 p.m. LPN-C stated she was not aware of bruising on R28's hands. LPN-C verified the bruises were present and should have been reported to the RN for assessment. LPN-C measured the bruised areas. The bruise located on R28's right hand was round and measured 1 centimeter (cm) long by (x) 1 cm wide. The bruise was located behind the knuckles of the3rd and 4th digits. On R28's left hand-one bruise was 2.5 cm in long x 1.5 cm in wide. This bruise was located behind the knucles of the 3rd and 4th digits and covered the area between the knuckles and wrist , the second bruise on the left hand measured 1.5 cm long x 1.5 cm wide. This bruise was located on the outer aspect of the wrist and extended onto the forearm. The third area was approximately dime sized and faded. This bruise was located behind the knuckle of the 1st digit and extended into the area between the thumb and first digit. When interviewed on 2/05/15, at 3:04 p.m. RN-A stated she was not previously aware of the	2 830		

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2 830	Continued From page 12 bruising on R28's hands. RN-A verified the presence of the bruises and further indicated they should have been reported and assessed. RN-A further stated depending on the size and type of injury an incident report would be filed or it might be documented in the nursing progress notes without filing a report. When interviewed on 2/5/15 at 3:40 p.m. the director of nursing (DON) stated that incident reports were not routinely completed for bruises. The DON further indicated if an area was small then a formal assessment was not necessary. In the instance of a large area or unknown cause then it would be monitored daily and the physician notified for orders on treatment. On 2/2/15 at 4:45 p.m. R62 was observed seated in her wheel chair in her room. A 1/2 inch dark purple bruise was noted to the top of her right arm. R62 could not identify where the bruise came from but stated no one hurt her, "I probably just bumped it." Also noted that the corners of R62's mouth and her chin were very red and rashy. On 2/5/15, at 9:19 a.m. R62 was seated in the dining room and her chin continued to have a pink rash and the corners of her mouth were red and irritated (skin crease's around chin). Another dark purple bruise was noted and was located just below the one noted on 2/2/15 on her right arm. R62 stated she got that yesterday and did not know how it occurred. The care plan dated 11/20/15 included skin conditions with interventions including: bruises easily and the bruises do not go away in a short time, staff need to be careful with positioning and transferring and the staff checks R62's skin a.m and HS [bedtime] for any redness/rash or open ares and notifies the licensed nurses of any	2 830		

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2 830	Continued From page 13	2 830		

concerns. Review of the medical record did not identify bruising or facial rash. The basic skin assessment dated 2/3/15 identified a skin irregularity labeled "Rash Breast."

When interviewed on 2/4/15, at 2:29 p.m. household support staff (HSS)-A and trained medication aide (TMA)-A stated if they discovered a new skin issue with a resident they would let the charge nurse know about it.

When interviewed on 2/4/15, at 2:36 p.m. LPN-A stated she had not seen any bruise and that this morning she didn't notice that R62's face was rashy. LPN-A stated she would check it later as R62 was in activities. She stated that if any new bruising or skin issue is found it should be reported to the nurse.

On 2/05/2015, 9:25 a.m. surveyor and LPN-C observed R62 in the dining room. LPN-C stated she had not seen the rash or bruises previously. She stated an incident report should be filled out for any bruising and reported to the registered nurse (RN). She also stated the aides are supposed to report any areas of bruising or skin problems to the nurse.

When interviewed on 2/5/15 at 9:30 a.m. RN-A stated she didn't know of any incident reports being filled out about bruises on R62. She stated that maybe the LPN had filled one out. She stated either herself or the LPN were responsible to fill out the incident reports. RN-A was unable to find documentation of the skin issues in the medical record.

On 2/2/15, at 5:28 p.m. R65 was observed seated in her room in her recliner. An approximate 1 centimeter purple/red bruise was noted on the top

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2 830	Continued From page 14 of R65's right elbow. R65 identified that the bruise occurred during the night from bumping the grab bar. She denied anyone hurting her. The care plan dated 10/30/14 included skin conditions with interventions including, staff check skin every am and HS for any signs of redness/rash or skin breakdown and will report any concerns to the licensed nurses. Review of the medical record did not identify the bruising. R65 receives 325 milligrams of aspirin everyday. When interviewed on 2/5/15, at 9:57 a.m. RN-A stated that she did not know about the bruise. She stated she did not know if anyone filled out an incident report on the bruise or whether the bruise had been identified. During an observation on 2/6/15, at 8:11 a.m. noted R5's right hand to be dry, rough and cracked along the knuckle areas of all five fingers. R5 reported that she has had trouble with her hands all her life and sometimes they would bleed. R5 reported that she tries to put lotion on them daily. R5's medical record indicated an admission date of 8/1/05 and diagnoses to include osteoporosis and history of pressure and stasis ulcers or sores. Documentation on the minimum data set (MDS) dated 12/3/14, indicated the brief interview for mental status (BIMS) of R5 identified moderate cognitive function. The plan of care (POC) last updated 6/16/14 indicated that R5 had a risk for skin breakdown due to peripheral vascular disease, diabetes, and also for pressure and stasis ulcer/sores. Interventions indicated that staff would check R5's legs, feet and heels daily for skin changes and notify the RN (registered nurse). The POC indicated that skin	2 830		

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2 830	Continued From page 15 would be checked weekly at bath time and that they would notify the nurse if there were any concerns. The record did not identify the dry, rough and cracked condition of R5's right hand. During an interview on 2/6/15, at 8:25 a.m. with the licensed practical nurse (LPN)- A indicated that there were no skin concerns with R5's hands. LPN-A inspected the right hand and verified that the skin was dry, rough and cracked and needed attention. LPN-A indicated the RN conducts skin assessments on admission, conduct weekly assessments on currently identified wound and skin conditions and staff were to report any changes to the nurse. During an observation on 2/5/15, at 3:27 p.m. noted R25 had a dark purple bruise between the knuckles of the 4th and 5th digits on the right hand and a dark purple bruise on the lower forearm of the same extremity. The medical record indicated that R25 had diagnoses which included cerebral vascular accident with right sided hemiparesis (paralysis). The MDS dated 11/27/14, the BIMS indicated cognition to be intact. The POC, last updated 12/4/14, indicated that R25 is at risk for skin problems, skin tears and bruised easily due to immobility. Interventions included staff to observe skin for redness, rash and open areas in the morning and at bedtime. Staff were to provide cares slow, tell R25 what they were doing and to be careful with transfers. The record did not identify the bruises on the right hand and forearm. During an observation/ interview on 2/5/15, at 3:47 p.m. LPN-B verified R25's bruises measured 1 centimeter (cm) diameter on the right forearm and 1.5 cm by 0.6 cm between the 4th	2 830		

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2 830	Continued From page 16	2 830		

and 5th digits on the right hand. LPN-B was not aware of the bruises and did not find them identified in the medical record. LPN-B reported that R25's skin should have been checked weekly with the bath.

During an interview on 2/5/15, at 3:41 p.m. the director of nursing (DON) indicated that skin was to be observed with cares and any concerns reported to the nurse. She further indicated there was no formal weekly skin assessment conducted by the nurse.

On 2/3/15, at 12:20 p.m. R123 was observed seated in his recliner in his room with purplish bruising noted to the top of his left hand and top of his right hand extending to the wrist. R123 could not identify how the bruising had occurred though stated it may have been while he was hospitalized. R123 further confirmed the bruising was not caused by abuse.

R123 was admitted to the facility on 1/30/15 as identified on the short term care plan dated 1/30/15. The short term care plan included skin conditions with interventions including: staff will observe for bleeding/bruising. The skin assessment dated 1/30/15 indicated: no skin irregularities.

When interviewed on 2/4/15, at 2:29 p.m. household support staff (HSS)-A and trained medication aide (TMA)-A stated if they discovered a new skin issue with a resident they would let the charge nurse know about it.

When interviewed on 2/5/15, at 8:41 a.m. licensed practical nurse (LPN)-D stated when a new skin issue is identified the staff are to report it to the nurse. When reported to an LPN the

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2 830	Continued From page 17 LPN in turn will notify the registered nurse (RN) to complete the initial assessment. LPN-D reviewed R123's electronic record and could not find documentation that bruising had been identified. LPN-D then observed R123's bruising to the top of the left hand and right hand/wrist and confirmed it should have been reported. LPN-D indicated she would notify the RN to complete an assessment. LPN-D further stated that inspection of the skin is to be completed twice daily when residents are gotten up in the morning and put to bed at night. LPN-D also confirmed that R123's bath day is on Tuesdays. When interviewed on 2/5/15, at 8:50 a.m. TMA-A confirmed she had assisted R123 with morning cares that day and did not notice bruising to the resident's right hand/wrist or top of left hand. TMA-A further stated that when she notices something out of the ordinary with a resident's skin she would notify the nurse. When interviewed on 2/5/15, at 3:40 p.m. the director of nursing (DON) stated a full body assessment is performed by the nurse upon admission. Direct care staff monitor skin with cares and also on bath day and will report changes to nursing if observed. DON stated with bruising an incident report is not completed unless it is a large area or if staff cannot determine how the bruising occurred. On 2/5/15, at 4:36 p.m. the surveyor and DON observed R123 lying on his back in his room. The DON confirmed the large bruised area on the resident's right hand/wrist should have been addressed on the admission skin assessment if present at time of admission or if new reported to the nurse and investigated. DON and surveyor viewed the purplish discoloring on R123's left	2 830		

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2 830	Continued From page 18 hand. DON was questionable as whether the area was actually bruising or discoloring of the skin though confirmed it should have been noted on the admission skin assessment Review of the skin assessment dated 2/5/15 at 16:00 (4:00 p.m.) included: bruise right hand, old iv (intravenous) site, bruising 4 x (by) 3 (measurement was not identified as inches or centimeters), bruise left hand, 2.0 cm long x 2.0 cm wide, old iv site brown. When interviewed on 2/6/15, at 8:45 a.m. administrator confirmed that bruising should be reported to the nurse and investigated/monitored when identified. The policy titled, Pressure Ulcer Prevention Program Description, reviewed 4/14 included: B. Interventions (for prevention of pressure ulcers) 5. Monitoring - Expectations a. Daily inspection of skin condition is required. b. Report any changes in skin condition to supervising nurse. SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could educate all licensed staff on the need to monitor non-pressure skin conditions and/or non-pressure skin conditions present on residents upon admission to the facility. The director of nursing could develop an audit to monitor staff compliance with the policy. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 830		

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AVERA MORNINGSIDE HEIGHTS CARE CENTE	300 SOUTH BRUCE STREET MARSHALL, MN 56258

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21525	Continued From page 19	21525		
21525	MN Rule 4658.1305 A.B.C Pharmacist Service Consultation A nursing home must employ or obtain the services of a pharmacist currently licensed by the Board of Pharmacy who: A. provides consultation on all aspects of the provision of pharmacy services in the nursing home; B. establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and C. determines that drug records are accurately maintained and that an account of all controlled drugs is maintained. This MN Requirement is not met as evidenced by: Based on observation interview and document review the facility failed to assure medications were available to residents in a timely manner for 1 of 25 residents (R65) who was observed during medication pass. Findings include: During observation of the medication pass on 2/2/15 at 7:00 p.m. trained medication aide (TMA)-A was observed to set up medications for R65. The medication administration record (MAR) identified R65 was to receive Lantanoprost 0.005% eye drops, one drop to each eye. TMA-A removed a bottle of eye drops labeled Cosopt from R65's medication cabinet. TMA-A looked at the bottle and compared it to the MAR. She stated, "ya, this is it, it's the right one, it's the only one that is in there". At this point TMA-A was going to instill the Cosopt eye drops in to R65's eyes. The Surveyor stopped TMA-A from	21525	Corrected	3/18/15

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21525	Continued From page 20	21525		

administering the incorrect medication. TMA-A then indicated she needed to check with the nurse. At 7:30 p.m. licensed practical nurse (LPN)-C was asked to come to R65's room. TMA-A explained that there were no Lantanoprost eye drops in R65's room. LPN-C checked the medication cabinet and confirmed R65 did not have any Lantanoprost eye drops in the cabinet. LPN-C indicated the Cosopt eye drops had been discontinued on 1/26/15, and did not know why there were no Lantanoprost eye drops available.

Review of the medication records from 9/14/14 to 2/5/15 identified the facility staff were signing out the Lantanoprost drops as being either administered or refused.

During interview with the director of nursing (DON) on 2/5/15 at 10:00 a.m. she brought a packing slip from the pharmacy dated 9/3/14. The packing slip identified that the facility received Latanoprost 0.005% drops for R65 on that date. The DON stated that this was the last time the facility received the medication. She stated she did not know why the medication was not reordered.

During interview with the consultant pharmacist on 2/6/15, at 9:15 a.m. he indicated the Latanoprost drops were good for 42 days after opening. He stated the Latanoprost bottle should be dated when opened and discarded 42 days after opening. He verified that the last bottle ordered was delivered on 9/3/14.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) and the Consulting Pharmacist could establish a system to monitor eye drop expiration dates and ensure there is a policy to instruct nurses on documentation and

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21525	Continued From page 21 adhering to the expiration dates. The DON could randomly audit the system and report audits to the quality assurance committee. TIME PERIOD OF CORRECTION: Fourteen (14) days.	21525		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate	21530		3/18/15

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21530	Continued From page 22 justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review the pharmacist failed to identify the need for mood and behavior monitoring following an increased daily dose of an antidepressant for 1 of 5 residents (R76) reviewed for unnecessary medications. Findings include: R76 was admitted to the facility on 6/16/14. Review of R76's history and physical by the physician dated 6/16/14 indicated medications to include sertraline (an antidepressant) 25 milligrams (mg) daily. Review of the physician orders dated 8/25/14 included an order to increase sertraline to 50 mg daily. Review of the care plan dated 10/17/14 included: "I do not want to be sad or depressed. I want to maintain my memory and realize that it has declined. I have had depression in the past. Continue to give the medications per order. The staff will watch me for changes in my mood or indicators of depression. The social worker will do a depression screen quarterly." Review of the quarterly minimum data set (MDS) assessment dated 9/20/14 indicated a PHQ-9	21530	Corrected	

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21530	Continued From page 23 (Resident Mood Interview) with a score of "0" indicating no depressive symptoms. The following and most recent MDS assessment dated 12/11/14 indicated a PHQ-9 score of "5" indicating mild depressive symptoms. Review of the electronic medical record indicated R76's mood and behavior was monitored from 6/17/14 - 6/22/14 with no mood and behaviors identified. The facility was unable to provide further evidence related to monitoring of R76's mood and behavior other than the quarterly MDS assessments. Review of the monthly pharmacy medication regimen reviews dated, 9/25/14, 10/25/14, 11/25/14, 12/26/14, and 1/26/15 did not identify the need for monitoring of mood and behavior related to the antidepressant use. When interviewed on 2/05/2015, at 4:24 p.m. the director of nursing (DON) confirmed monitoring of R76's mood and behavior had not been completed following the increase of the antidepressant medication (sertraline). The facility pharmacist was not available for interview during the survey. Although the director of pharmacy services was interviewed on 2/06/2015, at 8:52 a.m. indicated he would expect staff to be monitoring mood and behavior with the increase of an antidepressant. SUGGESTED METHOD OF CORRECTION: The facility could develop a system to ensure that mood and behavior monitoring is documented after a change in a medication dose ordered for behavior management. An audit could be conducted and reported to the quality assurance committee to ensure implementation has	21530		

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21530	Continued From page 24 occurred. TIME PERIOD FOR CORRECTION: Twenty -one (21) days.	21530		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to adequately monitor resident mood and behavior response following an increased antidepressant dose for 1 of 5 residents (R76) reviewed for unnecessary medications.	21540	Corrected	3/18/15

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21540	Continued From page 25 Findings include: R76 was admitted to the facility on 6/16/14. Review of R76's history and physical by the physician dated 6/16/14 indicated medications that included sertraline (an antidepressant) 25 milligrams (mg) daily. Review of the physician orders dated 8/25/14, included an order to increase the sertraline dose from 25 mg daily to 50 mg daily. Review of the care plan dated 10/17/14 included: "I do not want to be sad or depressed. I want to maintain my memory and realize that it has declined. I have had depression in the past. Continue to give the medications per order. The staff will watch me for changes in my mood or indicators of depression. The social worker will do a depression screen quarterly." Review of the quarterly minimum data set (MDS) assessment dated 9/20/14 indicated that R76 had been assessed with a PHQ-9 (Resident Mood Interview) score of "0", indicating no depressive symptoms. The following and most recent MDS assessment dated 12/11/14 indicated a PHQ-9 score of "5", indicating mild depressive symptoms. Review of the electronic medical record indicated R76's mood and behavior was monitored from 6/17/14 - 6/22/14 with no identified mood and behaviors. The facility was unable to provide further evidence related to monitoring of R76's mood and behavior other than the quarterly MDS assessments. When interviewed on 2/05/2015, at 4:24 p.m. the director of nursing (DON) confirmed R76's mood	21540		

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21540	Continued From page 26 and behavior had not been monitored following the increase of the antidepressant medication (sertraline) on 8/25/14. The facility pharmacist was not available for interview during the survey. Although the director of pharmacy services was interviewed on 2/06/2015, at 8:52 a.m. indicated he would expect staff to be monitoring mood and behavior with the increase of an antidepressant. SUGGESTED METHOD OF CORRECTION: The director of nursing and or designee could assure that policies and procedures are updated and that staff training has been completed to assure each resident's drug regimen is monitored and that residents are not taking unnecessary drugs. An auditing tool could be developed to monitor compliance, with involvement of the facility's consultant pharmacist, to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty -one (21) days.	21540		