DEPARTMENT OF HEAL	MEDIC	ARE/MEDICAL			CENTERS FOR ME AND TRANSMITTAL FE SURVEY AGENCY	DICARE & MEDICAID SERVICES ID: AG4J Facility ID: 00343
1. MEDICARE/MEDICAID PROVI (L1) 245228 2.STATE VENDOR OR MEDICAID (L2) 019545601	DER NO.	3. NAME AND AI	DDRESS OF FAC RNINGSIDE 1 BRUCE STR	CILITY HEIGHTS	CARE CENTER (L6) 56258	4. TYPE OF ACTION: <u>7</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9) 11/02/2009 6. DATE OF SURVEY 04/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/02//2015 ^(L34)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	JPPLIER CATEG 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	ORY 09 ESRD 10 NF 11 ICF/IID 12 RHC	02_ (L7) 13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE	7. On-Site Visit 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 09/30
 11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 	76 (L18)	Complianc			And/Or Approved Waivers O 2. Technical Personne 3. 24 Hour RN 4. 7-Day RN (Rural Si 5. Life Safety Code	7. Medical Director
13.Total Certified Beds	76 (L17)	Requirem	ents and/or Appli	ed Waivers:	* Code: A	(L12)
14. LTC CERTIFIED BED BREAKD	OWN				15. FACILITY MEETS	
18 SNF 18/19 SNF 76	F 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REL	MARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION 1	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL Date:
Kathryn Serie, Unit Su	pervisor	(04/02/2015	(L19) K	amala Fiske-Downing,	Enforcement Specialist 04/06/2015
PA	ART II - TO BE	COMPLETED I	BY HCFA RE	GIONAI	OFFICE OR SINGLE S	STATE AGENCY
 DETERMINATION OF ELIGIB <u>X</u> 1. Facility is Eligible to <u>2</u>. Facility is not Eligible 	Participate		IPLIANCE WITH HTS ACT:	H CIVIL		ancial Solvency (HCFA-2572) rol Interest Disclosure Stmt (HCFA-1513) // / // // // // // // // // // // // /
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	1ENT	26. TERMINATION ACTION	J: (L30)
OF PARTICIPATION 08/01/1979	BEGINNING	G DATE	ENDING DA	ГЕ	VOLUNTARY 0 01-Merger, Closure	0 <u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbur	
25. LTC EXTENSION DATE:		VE SANCTIONS n of Admissions:			03-Risk of Involuntary Terminati 04-Other Reason for Withdrawal	OTHER
(L27)	(L44) uspension Date:				00-Active	
28. TERMINATION DATE:	20	. INTERMEDIARY	(L45)		30. REMARKS	
		03001				
	(L28)	05001		(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	I OF APPROVAL	DATE		
	(L32)	03/27/2015		(L33)	DETERMINATION APP	PROVAL



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,

Kumalu Fiske Downing

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



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,

Kumalu Fiske Downing

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

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245228	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 4/2/2015
Name of Facility			Street Address, City, State, Zip Code	
AV	ERA MORNINGSIDE HEIGHTS CAR	E 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
	F0174 483.10(k),(l)	Correction Completed 03/18/2015			Correc Compl 03/18/:	eted		F0309 483.25		Correction Completed 03/18/2015
ID Prefix Reg. #		Correction Completed 03/18/2015	ID Prefix	_F0425 483.60(a).(b)	Correc Compl 03/18/:	eted	ID Prefix Reg. #			Correction Completed 03/18/2015
ID Prefix Reg. # LSC							Reg. #			Correction Completed
ID Prefix Reg. # LSC										
Reg. #			Reg. #				D //			
Reviewed I State Agen Reviewed I CMS RO	cy KS	viewed By /kfd viewed By	Date: 04/02/20 Date:)15	of Surveyor: of Surveyor:	03	3048		Date: Date:	04/02/2015
Followup t	o Survey Comple 2/6/2015			Check for any Uncorrected			encies. Was a -2567) Sent to		YES	NO

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245228	(Y2) Multiple Cons A. Building B. Wing		W BUILDING AND RENOVATED EXI	(Y3) Date of Revisit 3/23/2015		
Name of Facility			Street Address, City, State, Zip Code				
AV	ERA MORNINGSIDE HEIGHTS CAR	E 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		С	orrection ompleted 2/06/2015	ID Prefix		Correction Completed	ID Pre	əfix		Correction Completed
	NFPA 101						Reg	g. # SC		
LSC	K0143			LSC			L	SC		
		C	orrection			Correction				Correction
ID Prefix		С	ompleted	ID Prefix		Completed	ID Pro	efix		Completed
Reg. #				Reg. #						
-							Ĺ	g. # SC		
		С	orrection			Correction				Correction
ID Drefit		С	ompleted	ID Drafin		Completed		- fix		Completed
								efix		
Reg. # LSC				Reg. # LSC			L	g. # SC		
		C	orrection			Correction				Correction
ID Prefix		С	ompleted	ID Prefix		Completed	ID Pre	efix		Completed
Reg. #				Dec. #			_			
LSC				LSC			L	g. # SC		
ID Prefix		С	orrection ompleted	ID Prefix		Correction Completed	ID Pre	əfix		Correction Completed
Reg. #				Bog #			Dec	. <i>щ</i>		
LSC				LSC			L	sc		
Reviewed I	By Rev	viewed B	Sy.	Date:	Signature of Sur	veyor:			Date:	
State Agen	cy PS	/kfd		04/02/2015		1	9251			03/23/2015
Reviewed I CMS RO	By Rev	viewed B	Sy.	Date:	Signature of Sur	veyor:			Date:	
Followup t	o Survey Comple 2/4/2015			(Check for any Uncor Uncorrected Defic				YES	NO

DEPARTMENT OF H	MEDIC	ARE/MEDICAI			CENTERS FOR ME		ID: AG4J
1. MEDICARE/MEDICAID (L1) 245228 2.STATE VENDOR OR MEI (L2) 019545601	PROVIDER NO.	3. NAME AND AI	DDRESS OF FAC RNINGSIDE I BRUCE STRI	ULITY HEIGHTS	TE SURVEY AGENCY S CARE CENTER (L6) 56258	 TYPE OF ACTION Initial Termination Validation 	 Recertification CHOW Complaint
 5. EFFECTIVE DATE CHAR (L9) 11/02/2009 6. DATE OF SURVEY 8. ACCREDITATION STAT 0 Unaccredited 2 AOA 	02/06/2015 (L34)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	JPPLIER CATEG 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	ORY 09 ESRD 10 NF 11 ICF/III 12 RHC	02 (L7) 13 PTIP 22 CLIA 14 CORF D 15 ASC 16 HOSPICE	7. On-Site Visit 8. Full Survey Afte FISCAL YEAR ENDI 09/30	-
 11LTC PERIOD OF CERTINATION (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 	FICATION76 (L18)76 (L17)	Complianc 1. A X B. Not in Con	nce With equirements te Based On: cceptable POC	ram	And/Or Approved Waivers Or 2. Technical Personne 3. 24 Hour RN 4. 7-Day RN (Rural SI 5. Life Safety Code * Code: B	16. Scope of Se 7. Medical Dir	rvices Limit rector m Size
14. LTC CERTIFIED BED B	REAKDOWN	_			15. FACILITY MEETS		
	/19 SNF 19 SNF 76 (L38) (L39)	ICF (L42)	IID (L43)		1861 (e) (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGEN				DATE):			
17. SURVEYOR SIGNATU	RE	Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:
<u>Wendy Buckholz, H</u>			03/16/2015	(L19)	Kamala Fiske-Downing,		ialist 03/26/2015 (L20)
19. DETERMINATION OF 1. Facility is El 2. Facility is not	ELIGIBILITY igible to Participate	20. COM	BY HCFA RE IPLIANCE WITH HTS ACT:			ancial Solvency (HCFA-257 rol Interest Disclosure Stmt	
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEM	1ENT	26. TERMINATION ACTION	1:	(L30)
OF PARTICIPATION 08/01/1979	BEGINNING	5 DATE	ENDING DAT	ГЕ	VOLUNTARY 0 01-Merger, Closure		<u>NTARY</u> Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburg 03-Risk of Involuntary Terminati		Meet Agreement
25. LTC EXTENSION DAT	A. Suspension	VE SANCTIONS n of Admissions: nspension Date:	(L44)		04-Other Reason for Withdrawal	OTHER	er Status Change
	D. Resented	ispension Date.	(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY	. ,		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1	539 32	. DETERMINATION	I OF APPROVAL	DATE			
	(L32)			(L33)	DETERMINATION APP	PROVAL	



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;

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor Minnesota Department of Health 1400 E. Lyon Street Marshall, Minnesota 56258 <u>Kathryn.serie@state.mn.us</u> 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. Avera Morningside Heights Care Center February 24, 2015 Page 4

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

Avera Morningside Heights Care Center February 24, 2015 Page 5

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 Avera Morningside Heights Care Center February 24, 2015 Page 6

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 <u>Kamala.Fiske-Downing@state.mn.us</u> Telephone: (651) 201-4112 Fax: (651) 215-9697

		AND HUMAN SERVICES		FORM	APPROVED
		& MEDICAID SERVICES		OMB NO.	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY IPLETED
		245228	B. WING _		06/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
AVERA N	IORNINGSIDE HEIGH	ITS CARE CENTER		300 SOUTH BRUCE STREET MARSHALL, MN 56258	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 COMMENT	ſS	F 00	00	
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	of correction (POC) will serve f compliance upon the otance. Because you are your signature is not required first page of the CMS-2567 nic submission of the POC will tion of compliance.			
F 174 SS=D	on-site revisit of you validate that substa regulations has bee your verification. 483.10(k),(I) RIGHT	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with T TO TELEPHONE ACCESS	F 17	74	3/18/15
		e right to have reasonable f a telephone where calls can			
	personal possessio furnishings, and ap permits, unless to c	e right to retain and use			
	by: Based on interview facility failed to thor missing personal p	NT is not met as evidenced and document review, the oughly investigate reports of roperty for 1 of 2 residents that was reviewed for personal		 Policy developed for Missing Items Review policy on missing items and process for missing items will be reviewed with all staff at staff meeting on March 18, 2015 Staff will ask resident and/or family members if they have had any missing 	
		ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE 03/09/2015
LIECTION	ically Signed				03/09/2013

Electronically Signed

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.

		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUUTI	PLE CONSTRUCTION	OMB NO.	0938-035 E SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		IG		PLETED
		245228	B. WING _		02/	06/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
AVERA N	ORNINGSIDE HEIGH	ITS CARE CENTER		300 SOUTH BRUCE STREET MARSHALL, MN 56258		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 174	Continued From pa	ge 1	F 17			
	p.m. indicated R71 afghan/shawl that a F-A stated he thoug she had been sick, further indicated he to the facility staff b since. He stated, "I The social worker (2/5/15, at 10:00 a.m anything about that protocol for missing missing item report report would go to t nursing (DON) and further implied that to the staff and look stated that if an aid they should talk to t report to her or the they would then foll	er (F)-A on 2/2/15, at 5:45 was missing a purple ladies aide had given her. that it was given to her when about a month ago. F-A had reported the missing item ut had received a response guess they just gave up on it." SW) was interviewed on n. She stated, "I don't know " She indicated the facility items was to complete a . The SW then implied that the he administrator, director of nursing aide supervisor. She one of the people would talk a for the missing item. She e identified a missing item, he registered nurse and then director of nursing. She stated ow up with the resident/family d not be found it would be		items at care conference tim up if any reported. 4. Spread sheet will bedeve track missing items, report o items to LTC Quality Meeting months, quarterly thereafter.	loped that will f missing g monthly x 3	
((; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ;	(LPN)-B and LPN-C aware of the missin stated, "Oh no, no, that." LPN-C hesita sure" On 2/5/15, at 4:33 p	o.m. licensed practical nurse Were asked if they were g afghan/shawl. LPN-B I didn't hear anything about ted and stated, "I'm not real o.m. nursing assistant (NA)-B				
	approximately a mo purplish afghan and over for it" and she	ered the item going missing onth ago. She stated it was a d stated "We [staff] looked all thought they were going to undry but she never heard any				

If continuation sheet Page 2 of 26

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/09/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245228	B. WING			02/(06/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
AVERA N	IORNINGSIDE HEIGH	TS CARE CENTER			00 SOUTH BRUCE STREET IARSHALL, MN 56258		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 174	more about it. She s about the afghan m which nurse it was. On 2/5/15, at 4:30 p facility. F-A was ask had told about the r stated, "I told every everyone." F-A was worker about the m did. I have it written to get it." F-A stated three times a day a had not heard anyth afghan/shawl. F-A s out as it was too so around the time his On 2/5/15, at 4:36 p supervisor when as afghan/shawl stated you know he tells m to remember On 2/6/15, at 9:20 a R71's F-A had state about the missing a don't recall. He is in I don't remember ev Review of the unda regarding SAFEKEI investigates all lost responsible for lost urges discretion in b items." Although the	stated she told the nurse issing but could not recall o.m. R71's F-A arrived at the ked which staff member he nissing afghan/shawl. He one, the nurses, aides asked if he had told the social issing item. F-A stated, "Yup I down at home if you want me d that he was at the facility nd he had told everyone and hing more about the missing stated he figured it got thrown iled to wash since that was wife had the flu. o.m. the nursing aide ked about the missing d, "Well I don't recall that but he so much stuff that it's hard " a.m. the SW was informed ad specifically he had told her fighan/shawl. She stated, "I here four to five times a day, verything he says." ted resident care policy EPING noted, "The facility items, but is not financially or damaged items. The facility pringing valuable personal e facility was aware of the facility did not assist R71 in	F 1	74			

Facility ID: 00343

If continuation sheet Page 3 of 26

		AND HUMAN SERVICES			F	ORM	03/09/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				3) DATE	E SURVEY PLETED
		245228	B. WING _			02/0	06/2015
NAME OF I	PROVIDER OR SUPPLIER	I		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
AVERA N	IORNINGSIDE HEIGH	ITS CARE CENTER			0 SOUTH BRUCE STREET ARSHALL, MN 56258		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 282 F 282 SS=E	PERSONS/PER CA The services provic must be provided b	RVICES BY QUALIFIED	F 28 F 28				3/18/15
	by: Based on observat review the facility fa of care related to th non-pressure related residents (R28, R62 Findings include: During observation noted R28 had thre on the top of his lef top of his right hand	NT is not met as evidenced tion, interview, and document ailed to follow the written plan be identification of ed skin issue for 5 of 6 2, R65, R123, R25) reviewed. on 2/5/15, at 11:47 a.m. it was be dark purple bruises located t hand and one located on the d. R28 and family (F)-B denied or when these bruises had			 Facility policy on skin care update reflect non-pressure related skin care reporting. Care plans for residents identified survey updated to reflect current skin condition(s). Review policy with staff at all staff meeting on March 18, 2015 On-goining quality monitoring of compliance with policy/process will be completed and reported to LTC Qualit Committee, monthly x 3 months, quar thereafter. 	e and in e ty	
	staff would check the bedtime for red, ras and report concerna- did not include mor identified skin issue						
	The signed Physician Orders dated 12/16/14, indicated R28 received 81 milligrams (mg) Aspirir daily.						
		Set (MDS) dated 12/24/14, severe cognitive impairment					

If continuation sheet Page 4 of 26

		& MEDICAID SERVICES	()(0) 1). 0938-039
-	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY MPLETED
		245228	B. WING _		02	/06/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	=	
AVERA	MORNINGSIDE HEIGH	TS CARE CENTER		300 SOUTH BRUCE STREET MARSHALL, MN 56258		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 282	and required extense mobility, transfers, o care, and ambulation F-B was interviewed stated R28 had falle know if that could h they were from som Nursing assistant (N 2/5/15, at 12:09 p.m aware R28 had brui Licensed practical m interviewed on 2/5/1 the procedure follow identified was to non nurse (RN). The RN assessment, and fill was indicated. Durin 2/5/15, at 2:35 p.m. aware of bruising on the bruises were pro- reported to the regis assessment. LPN-O The bruise was loca round and measure (x) 1 cm wide. The knuckles of the 3rd hand-one bruise was wide. The bruise was of the 3rd and 4th d between the knuckl bruise on the left ha 1.5 cm wide. The bruise was	A single case of the bed bed bed bed bed bed bed bed bed be	F 28	32		

Facility ID: 00343

If continuation sheet Page 5 of 26

		AND HUMAN SERVICES				FORM	03/09/2015 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245228	B. WING			02/	06/2015	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•		
AVERA N	IORNINGSIDE HEIGH	ITS CARE CENTER		-	00 SOUTH BRUCE STREET IARSHALL, MN 56258			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIJ TAG	ĸ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 282	at 3:04 p.m. RN-As any bruising on R24 staff was to notify the resident bruise or of then complete an a doctor. Following of areas on R28's har areas should have nurse, assessed ar electronic record in being updated. The for R28 for reportin skin condition. R62 was observed her room on 2/2/15 purple bruise was of arm. R62 could not from but stated "I p resident was also of area on the corners On 2/5/15, at 9:19 a dining room. R62's rash on the corners R62 was also obse bruise just below th her right arm. R62 noticed the bruise y how it occurred. The MDS dated 11/ severely cognitively plan dated 11/20/14 skin conditions. Inter required to be care	humb and first digit. onducted with RN-A on 2/5/15, stated she was not aware of 8's hands. She further stated he charge nurse regarding a ther injury and the RN would ssessment and update the bservation of the bruised hds, RN-A verified that the been reported to the charge hd documented in the addition to the physician e plan of care was not followed g and monitoring of the current seated in her wheel chair in , at 4:45 p.m. A 1/2 inch dark observed on the top of her right recall where the bruise came robably just bumped it." The bserved to have a red rashy s of her mouth and on her chin. a.m. R62 was sitting in the chin continued to have a red s of her mouth and on her chin. rved to have a dark purple the bruise noted on 2/2/15 on indicated at that time that she vesterday but did not know (6/14, indicated R62 was rimpaired. Review of the care 4, identified a focus topic of erventions listed; staff was ful with positioning and		82	DEFICIENCY)			
	transferring the res	ident due to the resident f to check the resident's skin						

If continuation sheet Page 6 of 26

	-	AND HUMAN SERVICES			FORM	: 03/09/2015 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G	(X3) DAT	E SURVEY IPLETED
		245228	B. WING		02/	06/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AVERA I	MORNINGSIDE HEIGH	ITS CARE CENTER		300 SOUTH BRUCE STREET MARSHALL, MN 56258		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 282	in the a.m. and p.m any redness/rash o notify the charge nu Review of the skin a identified a skin irre but did not include t rash. When interviewed of household support medication aide (TM unaware of the resi or skin rash. They k identified these skin charge nurse. When interviewed of indicated she was u right arm nor did sh rash that a.m. wher indicated that all ide reported to the nurs On 2/05/2015, at 9: R62's bruises on he LPN-C indicated sh or bruises previous that an incident rep completed for any it to the RN. She also identified these skin to the charge nurse When interviewed of indicated there had investigation compl further confirmed sl	. with cares and observe for r open areas. The staff should urse if concerns are identified. assessment dated 2/3/15, egularity labeled "Rash Breast." the identified bruising or facial on 2/4/15, at 2:29 p.m. staff (HSS)-A and trained WA)-A indicated they were dents bruise on the right arm ooth indicated if they had n issues they would notify the on 2/4/15, at 2:36 p.m. LPN-A unaware of R62's bruise on her ne notice the residents facial n observed with cares. LPN-A entified skin issues should be se. 25 a.m. LPN-C confirmed er right arm and facial rash. he had not observed the rash ly. LPN-C further included ort should have been dentified bruising and reported o stated the NA should have n issues with cares and report	F 282	2		

If continuation sheet Page 7 of 26

		AND HUMAN SERVICES				FORM	APPROVED
	<u>RS FOR MEDICARE</u> OF DEFICIENCIES					I	0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245228	B. WING			02/	06/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH BRUCE STREET		
AVERA N	IORNINGSIDE HEIGH	ITS CARE CENTER			ARSHALL, MN 56258		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		COMPLETION DATE
					DEFICIENCY)		
F 282	Carting of From no		 	~~~			
F 202	Continued From pa her right arm or fac	-	F2	282			
	ner nyni ann or iac	lai fasn.					
		seated in her room in her at 5:28 p.m. The resident was					
		in approximate 1.0 centimeter					
	purple/red bruise or	n the top of her right elbow.					
		se occurred during the night grab bar. She denied anyone					
	hurting her.	Ido bal. She denied anyone					
	-						
		d 10/30/14, included skin rventions including, staff to					
		m. and p.m. for any signs of					
	redness/rash or ski	in breakdown and report any					
		ensed nurse. Review of the not identify the bruising.					
	medical record did	ກິບເກີບຢາແກງ ເກຍ ນານາຣິກາງ.					
		/26/15, indicated R65 to be					
	moderately cognitiv	ely impaired.					
	When interviewed of	on 2/5/15, at 9:57 a.m. RN-A					
	stated she was una	aware of the residents bruise.					
	RN-A verified staff I on R65's arm.	had not identified the bruise					
		d seated in his recliner in his					
		bruising noted on the top of his f his right hand extending to					
		at 12:20 p.m. R123 could not					
	identify how the bru	ising had occurred, but					
		ve been during his recent					
	hospital stay from a	i initavenous site.					
		hort term care plan dated					
		he resident was admitted to					
		15. The care plan included a conditions. Interventions					
		observe for bleeding/bruising.					

If continuation sheet Page 8 of 26

		AND HUMAN SERVICES				FC	ORM /	APPROVED
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION			0938-0391
	OF CORRECTION	IDENTIFICATION NUMBER:				(PLETED
		245228	B. WING				02/(06/2015
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	S	STREET ADDRESS, CITY, STATE, ZIP CODE	1	<u> </u>	0,2012
AVERA N	ORNINGSIDE HEIGH	ITS CARE CENTER			BOO SOUTH BRUCE STREET			
	1		I	N	MARSHALL, MN 56258	~		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	Ē	(X5) COMPLETION DATE
F 282	Continued From pa	ge 8	F 2	282				
	1/30/15, identified F irregularities with no documentation in th	ssion skin assessment dated R123 as having no skin o bruising identified. No ne residents medical record o R123's bruising of the						
	indicated she had a cares, but did not no right or left hand. Th	on 2/5/15, at 8:50 a.m. TMA-A assisted R123 with morning otice bruising to the resident's MA-A further included when ise she is to report it to the						
	indicated she had n bruising. LPN-D obs bruising to the top o LPN-D further state was to be complete are gotten up in the	on 2/5/15, at 8:41 a.m. LPN-D not been aware of R123's served and verified R123's of the left hand and right hand. ed that inspection of the skin ed twice daily when residents a morning and put to bed at ruises should have been ted to the nurse.						
	(DON) confirmed th resident's right hand addressed on the a present or if the res	b.m. the director of nursing the large bruised area on the d/wrist should have been admission skin assessment if sident obtained the bruise after have been reported to the ated at that time.						
	facility administrator	on 2/6/15, at 8:45 a.m. the r confirmed R123's bruising dentified and reported to the ated/monitored.						

If continuation sheet Page 9 of 26

		AND HUMAN SERVICES	1			FORM	03/09/2015 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION		E SURVEY PLETED
		245228	B. WING			02/0	06/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
AVERA N	MORNINGSIDE HEIGH	ITS CARE CENTER			00 SOUTH BRUCE STREET IARSHALL, MN 56258		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	R25 to have had a the knuckles of the purple bruise on the extremity on 2/5/15 R25's Admission R diagnosis of cerebr sided hemiparesis 11/27/14, indicated The plan of care, la R25 was at risk for bruising easily due included staff to obtand open areas in the Staff were to provide they were doing and the record did not hand and forearm. During an observat 3:47 p.m. LPN-B m were 1 centimeter (forearm and 1.5 cm and 5th digits on the aware of the bruise identified in the methat skin was checked During an interview DON indicated there skin assessment. Twould expect the st and reporting change the care plan. The policy titled, Pr	dark purple bruise between 4th and 5th digits and a dark e lower forearm of the right , at 3:27 p.m. ecord dated 5/16/05, included al vascular accident with right (paralysis). The MDS dated R25's cognition to be intact. Ist updated 12/4/14, indicated skin problems, skin tears and to immobility. Interventions serve skin for redness, rash the morning and at bedtime. le cares slow, tell R25 what d to be careful with transfers. identify the bruises on the right ion and interview on 2/5/15, at easured the bruises and they (cm) diameter on the right n by 0.6 cm between the 4th e right hand. RN-B was not s and did not find them dical record. RN-B reported	F2	282			

If continuation sheet Page 10 of 26

		AND HUMAN SERVICES & MEDICAID SERVICES		FO	ED: 03/09/2015 RM APPROVED IO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3)	DATE SURVEY COMPLETED
		245228	B. WING		02/06/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
AVERA N	IORNINGSIDE HEIGH	ITS CARE CENTER		300 SOUTH BRUCE STREET MARSHALL, MN 56258	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC 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 282 F 309 SS=E	ulcers) 5. Monitoring - F a. Daily insp required. b. Report ar supervising nurse. 483.25 PROVIDE C HIGHEST WELL BI Each resident must provide the necessa or maintain the high mental, and psycho accordance with the and plan of care. This REQUIREMEN by: Based on observat review the facility fa skin issues for 6 of R123, R5, R25) rev related skin conditio	T prevention of pressure Expectations bection of skin condition is by changes in skin condition to CARE/SERVICES FOR EING receive and the facility must ary care and services to attain best practicable physical, social well-being, in e comprehensive assessment NT is not met as evidenced ion, interview, and document iled to identify and monitor 6 residents (R28, R62, R65, iewed for non-pressure	F 282	 Skin assessments completed on residents identified in survey. Facility policy on Skin Care updated and reviewed with staff at all staff meeti on March 18, 2015. On-going compliance will occur 	3/18/15
	p.m, R28 stated he gotten the bruised a spouse stated it mig R28 grabbing onto stated she thought	on/interview on 2/2/15, at 5:15 didn't know how he had areas on his hands. R28's ght have been caused from the stand up lift. She further the bruises had been there for concern about what had		through quality monitoring of residents skin conditions. Monitoring will validate compliance with facility policy. Monitori results will be reported to LTC Quality Committee monthly x 3 months, quarter thereafter.	ng

Facility ID: 00343

If continuation sheet Page 11 of 26

		AND HUMAN SERVICES				FORM	03/09/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245228	B. WING			02/	06/2015
NAME OF I	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE	-	
AVERA N	IORNINGSIDE HEIGH	ITS CARE CENTER		-	00 SOUTH BRUCE STREET ARSHALL, MN 56258		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	During an observat it was noted that R2 bruises located on one on the back of R28 was admitted of including advanced R28's quarterly min 12/24/14 included a Status (BIMS) indic impairment. The ca skin condition would and bedtime cares or changes and rep When interviewed of R28's spouse state previously and she had caused the bru R28's spouse state previously and she had caused the bru R28's spouse also any additional bruis occurred. When interviewed of nursing assistant (N aware that R28 had hands. When interviewed of licensed practical n procedure followed was to notify the ch The RN would then fill out the incident r During a subseque p.m. LPN-C stated on R28's hands. LI present and should	ion on 02/05/15, at 11:47 a.m. 28 had three (3) dark purple the back of his left hand and	F	309			

Facility ID: 00343

If continuation sheet Page 12 of 26

		AND HUMAN SERVICES			FORM	03/09/2015 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245228	B. WING		02/	06/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AVERA I	MORNINGSIDE HEIGH	ITS CARE CENTER		300 SOUTH BRUCE STREET MARSHALL, MN 56258		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	areas. The bruise I was round and mea by (x) 1 cm wide. T the knuckles of the left hand-one bruise cm in wide. This bi- knucles of the 3rd a area between the k bruise on the left ha 1.5 cm wide. This I outer aspect of the forearm. The third sized and faded. T the knuckle of the 1 area between the th When interviewed of stated she was not bruising on R28's h presence of the bru- should have been r further stated depe- injury an incident re- be documented in t without filing a repor When interviewed of director of nursing (reports were not ro The DON further in then a formal assess the instance of a lat then it would be mo- notified for orders of On 2/2/15 at 4:45 p in her wheel chair in purple bruise was not	located on R28's right hand asured 1 centimeter (cm) long The bruise was located behind 3rd and 4th digits. On R28's e was 2.5 cm in long x 1.5 ruise was located behind the and 4th digits and covered the nuckles and wrist, the second and measured 1.5 cm long x bruise was located on the wrist and extended onto the area was approximately dime This bruise was located behind 1st digit and extended into the numb and first digit. on 2/05/15, at 3:04 p.m. RN-A previously aware of the ands. RN-A verified the tises and further indicated they eported and assessed. RN-A nding on the size and type of eport would be filed or it might he nursing progress notes int.	F 309			

If continuation sheet Page 13 of 26

TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(NZ) WULL	TIPLE CONSTRUCTION	(A3) DA	(X3) DATE SURVEY		
		A. BUILDI	NG		MPLETED		
	245228	B. WING _		02	/06/2015		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E			
AVERA MORNINGSIDE HEIGH	TS CARE CENTER		300 SOUTH BRUCE STREET MARSHALL, MN 56258				
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE		
just bumped it." Als R62's mouth and he rashy. On 2/5/15, a in the dining room a a pink rash and the red and irritated (sk Another dark purple located just below th right arm. R62 state did not know how it The care plan dated conditions with inter easily and the bruise time, staff need to b transferring and the and HS [bedtime] for ares and notifies the concerns. Review o identify bruising or f assessment dated 2 irregularity labeled " When interviewed o household support s medication aide (TM a new skin issue with charge nurse know When interviewed o stated she had not s morning she didn't r rashy. LPN-A stated R62 was in activities bruising or skin issue reported to the nurs	ad no one hurt her, "I probably so noted that the corners of er chin were very red and it 9:19 a.m. R62 was seated and her chin continued to have corners of her mouth were in crease's around chin). by buise was noted and was he one noted on 2/2/15 on her ed she got that yesterday and occurred. d 11/20/15 included skin ventions including: bruises es do not go away in a short be careful with positioning and e staff checks R62's skin a.m or any redness/rash or open e licensed nurses of any of the medical record did not acial rash. The basic skin 2/3/15 identified a skin 'Rash Breast." on 2/4/15, at 2:29 p.m. staff (HSS)-A and trained MA)-A stated if they discovered th a resident they would let the about it. on 2/4/15, at 2:36 p.m. LPN-A seen any bruise and that this notice that R62's face was d she would check it later as s. She stated that if any new ue is found it should be	F 3(09				

If continuation sheet Page 14 of 26

		AND HUMAN SERVICES				FORM	03/09/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245228	B. WING			02/0	06/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
AVERA N	IORNINGSIDE HEIGH	ITS CARE CENTER		-	00 SOUTH BRUCE STREET IARSHALL, MN 56258		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	observed R62 in the she had not seen t She stated an incid for any bruising and nurse (RN). She als supposed to report problems to the nur When interviewed of stated she didn't kn being filled out about that maybe the LPN stated either hersel to fill out the incider find documentation medical record. On 2/2/15, at 5:28 p in her room in her re- centimeter purple/re- of R65's right elbow bruise occurred dur the grab bar. She of The care plan dated conditions with inter- skin every am and I redness/rash or ski any concerns to the the medical record R65 receives 325 n When interviewed of stated that she did She stated she did an incident report o	e dining room. LPN-C stated he rash or bruises previously. ent report should be filled out d reported to the registered so stated the aides are any areas of bruising or skin rse. on 2/5/15 at 9:30 a.m. RN-A low of any incident reports ut bruises on R62. She stated N had filled one out. She f or the LPN were responsible ht reports. RN-A was unable to of the skin issues in the o.m. R65 was observed seated ecliner. An approximate 1 ed bruise was noted on the top v. R65 identified that the ring the night from bumping denied anyone hurting her. d 10/30/14 included skin rventions including, staff check	F	309			

If continuation sheet Page 15 of 26

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED		
				NG				
		245228	B. WING _		02/06/20			
	PROVIDER OR SUPPLIER	HTS CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 300 SOUTH BRUCE STREET MARSHALL, MN 56258	=			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE		
F 309	During an observation noted R5's right had cracked along the lifingers. R5 reported her hands all her lifibleed. R5 reported them daily. R5's medical recorrof 8/1/05 and diagrand history of pressiones. Documenta (MDS) dated 12/3// for mental status (If moderate cognitive (POC) last updated a risk for skin breat vascular disease, or and stasis ulcer/so that staff would che daily for skin change (registered nurse). would be checked they would notify the concerns. The recorrough and cracked During an interview the licensed practic that there were no LPN-A inspected the skin was dry, ro attention. LPN-A in assessments on action assessments on comparison of the second starts on a comparison of the second start	tion on 2/6/15, at 8:11 a.m. Ind to be dry, rough and knuckle areas of all five d that she has had trouble with ie and sometimes they would that she tries to put lotion on d indicated an admission date tosses to include osteoporosis sure and stasis ulcers or ation on the minimum data set 14, indicated the brief interview BIMS) of R5 identified e function. The plan of care d 6/16/14 indicated that R5 had kdown due to peripheral diabetes, and also for pressure res. Interventions indicated eck R5's legs, feet and heels ges and notify the RN The POC indicated that skin weekly at bath time and that he nurse if there were any ord did not identify the dry, condition of R5's right hand. <i>y</i> on 2/6/15, at 8:25 a.m. with cal nurse (LPN)- A indicated skin concerns with R5's hands. he right hand and verified that bugh and cracked and needed dicated the RN conducts skin dmission, conduct weekly urrently identified wound and d staff were to report any	F 30	09				

If continuation sheet Page 16 of 26

STATE NUMBER OF DEFICIENCIES AND PLAN OF CORRECTION (X) INDEMIFICATION NUMBER IDENTIFICATION NUMBER (X) INDEMIFICATION A BUILDING			AND HUMAN SERVICES				FORM	03/09/2015 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2/P CODE AVERA MORNINGSIDE HEIGHTS CARE CENTER STREET ADDRESS, CITY, STATE, 2/P CODE MARSHALL, MN 56283 SOUTH BRUCE STREET MARSHALL, MN 56283 BROWMARY STATEMENT OF DEFICIENCES PROVIDERS PARCH OF CORRECTION MEED ADDRESS COTY, STATE, RECEDED BY FULL RECULATORY OF LSC DENTIFYING INFORMATION) PREEX TAG PROVIDERS PARCH OF CORRECTION F 309 Continued From page 16 noted R25 had a dark purple bruise between the knuckles of the 4th and 5th digits on the right hand and ad adr, purple bruise on the lower forearm of the same extremity. F 309 The medical record indicated that R25 had diagnoses which included cerebral vascular accident with right sided hemiparesis (paralysis). The MDS dated 11/2/1/4, the BIMS indicated cognition to be intract. The PCC, last updated 12/4/14, indicated that R25 is at risk for skin problems, skin tears and bruise deasily due to immobility. Interventions included salf to observe skin for redness, rash and open areas in the morning and at bedtime. Staff were to provide cares solw, tell R25 what they were doing and to be careful with transfers. The record did not identify the bruises on the right hand. LPN-B was not aware of the bruises and if no the reght forearm and 1.5 mbud have been checked weekly with the bath. During an interview on 2/5/15, at 3/47 p.m. LPN-B verified R25's bruises measured 1 contimiet record. LPN-B reported that R25's skin tokud 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 concerms reported to the nurse. The DON reported that she would expect	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '		E CONSTRUCTION	(X3) DATE	E SURVEY
AVERA MORNINGSIDE HEIGHTS CARE CENTER 300 SOUTH BRUCE STREET MARSHALL, MN 56283 PHEFX TAG SUMMARY STATEMENT OF DEFICIENCES IEACH DEFICIENCY MUST BE PRECEDED BY FULL REACH DEFICIENCY MUST BE PRECEDED BY FULL TAG IPREFX PROVIDER'S PLAN OF CORRECTION (EACH OPRIVE ADTION OR US: DEPICIENCY MUST BE PRECEDED BY FULL PREFX IPROVIDER'S PLAN OF CORRECTION (EACH OPRIVE ADTION OR US: DEPICIENCY MUST BE PRECEDED BY FULL TAG IPREFX IPROVIDER'S PLAN OF CORRECTION (EACH OPRIVE ADTION OR US: DEPICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED OT THE APPROPRIATE DEFICIENCY) IPREFX IPREFX IPROVIDER'S PLAN OF CORRECTION (EACH OPRIVE ADTION OR US: DEPICTION NOT DEFICIENCY) IPREFX F 309 Continued From page 16 noted R25 had a dark purple bruise on the lower forearm of the same extremity. F 309 IF 309 IPREFX The medical record indicated that R25 had diagnoses which included derebral vascular accident with right sided hemiparesis (paralysis). The MDS dated 11/27/14, Indicated that R25 had diagnoses, 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 bettime. Staff were to provide cares slow, tell R25 what they were doing and to be careful with transfers. The record did not torearm 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 is should have been checked weekly with the bath. Iprice of unurses. The DON reported that be bobserved with cares and any concerns reported to the nurse. The			245228	B. WING			02/	06/2015
AVERA MORNINGSIDE HEIGHTS CARE CENTER MARSHALL, MN 56258 [24] JD TAG SUMMARY STATEMENT OF DEFICIENCIES RECULATIONY MUST BE PRECEDED BY FULL RECULATIONY ON LSC DENTIFYING INFORMATION DE TAG PROVIDER'S PLAN OF CORRECTIVE (CARCH CORRECTIVE ACTOR NERO ENDERING CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMENTION DEFICIENCY) F 309 Continued From page 16 noted R25 had a dark purple bruise between the knuckles of the 4th and 5th digits on the fight hand and a dark purple bruise on the lower forearm of the same extremity. F 309 The medical record indicated that R25 had diagnoses which included cerebral vascular accident with right sided hemparesis (paralysis). The MDS dated 11/27/14, the BIMS indicated cognition to be intract. The PCO, 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 identified in the medical record. LPN-B werified R25's bruises measured 1 centimeter (cm) diameter on the right forearm and 1.5 cm by 0.6 cm between the 4th and Sth digits on the right hand. LPN-B we 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 kin was to be observed with cares and any concerns reported to the nurse. The DON reported that she would expect the staff to be monitoring the	NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PREFIX TAG (EACH CORRECTIVE ACTION SHOLL BE REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CEACH CORRECTIVE ACTION SHOLL BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION DEFICIENCY) F 309 Continued From page 16 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. F 309 The medical record indicated that R25 had diagnoses which included cerebral vascular accident with right sided hemiparesis (paralysis). The MDS date 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 Druised 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 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 on 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	AVERA M	IORNINGSIDE HEIGH	ITS CARE CENTER					
 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 11/2/1/4, 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 id 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 that skin exest to be observed with cares and any concerns reported that skin sessment conducted by the nurse. The DON reported that skin was to be observed with to be nurse. The DON reported that skin was to be word weekly skin assessment conducted by the nurse. The DON reported that skin was to be words expect the staff to be monitoring the 	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFI	x	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLETION
skin and reporting changes to the charge nurse.	F 309	noted R25 had a da knuckles of the 4th hand and a dark put forearm of the same The medical record diagnoses which ind accident with right s The MDS dated 11/ cognition to be intact 12/4/14, indicated th problems, skin tear immobility. Interver observe skin for rec the morning and at cares slow, tell R25 be careful with trans- identify the bruises During an observati 3:47 p.m. LPN-B vo measured 1 centim forearm and 1.5 cm and 5th digits on the aware of the bruise identified in the mea- that R25's skin show with the bath. During an interview director of nursing (to be observed with reported to the nurs was no formal week conducted by the nu-	ark purple bruise between the and 5th digits on the right urple bruise on the lower e extremity. A indicated that R25 had cluded cerebral vascular sided hemiparesis (paralysis). /27/14, the BIMS indicated ct. The POC, last updated hat R25 is at risk for skin s and bruised easily due to ntions included staff to dness, rash and open areas in bedtime. Staff were to provide 5 what they were doing and to sfers. The record did not on the right hand and forearm. ion/ interview on 2/5/15, at erified R25's bruises neter (cm) diameter on the right n by 0.6 cm between the 4th e right hand. LPN-B was not is and did not find them dical record. LPN-B reported uld have been checked weekly on 2/5/15, at 3:41 p.m. the (DON) indicated that skin was n cares and any concerns se. She further indicated there kly skin assessment urse. The DON reported that he staff to be monitoring the		809	DEFICIENCY)		

Facility ID: 00343

If continuation sheet Page 17 of 26

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		245228	B. WING			02/	06/2015
NAME OF I	PROVIDER OR SUPPLIER		·	5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>, </u>	
AVERA N	IORNINGSIDE HEIGH	ITS CARE CENTER			300 SOUTH BRUCE STREET MARSHALL, MN 56258		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	Continued From pa	ge 17	F 3	809	,		
	seated in his recline bruising noted to the of his right hand exi- could not identify ho though stated it ma hospitalized. R123 was not caused by R123 was admitted identified on the short conditions with inter observe for bleedin assessment dated irregularities. When interviewed of household support medication aide (TM a new skin issue wi charge nurse know When interviewed of licensed practical n new skin issue is id it to the nurse. Whe LPN in turn will noti complete the initial R123's electronic re documentation that LPN-D then observ of the left hand and confirmed it should indicated she would assessment. LPN- inspection of the sk	to the facility on 1/30/15 as ort term care plan dated term care plan included skin rventions including: staff will g/bruising. The skin 1/30/15 indicated: no skin on 2/4/15, at 2:29 p.m. staff (HSS)-A and trained MA)-A stated if they discovered th a resident they would let the					

Facility ID: 00343

If continuation sheet Page 18 of 26

PRINTED: 03/09/2015

		AND HUMAN SERVICES				FORM	: 03/09/2015 APPROVED . 0938-0391
		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DAT	(X3) DATE SURVEY COMPLETED	
		245228	B. WING	i		02/	06/2015
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AVERA N	ORNINGSIDE HEIGH	HTS CARE CENTER			300 SOUTH BRUCE STREET MARSHALL, MN 56258		
		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(ME)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	Continued From pa	age 18		309	0		
		ight. LPN-D also confirmed		503			
	confirmed she had cares that day and resident's right han TMA-A further state something out of th skin she would noti When interviewed of director of nursing assessment is perf admission. Direct of cares and also on the changes to nursing bruising an inciden unless it is a large of determine how the On 2/5/15, at 4:36 pobserved R123 lyin	on 2/5/15, at 3:40 p.m. the (DON) stated a full body formed by the nurse upon care staff monitor skin with path day and will report if observed. DON stated with t report is not completed area or if staff cannot					
	resident's right han addressed on the a present at time of a the nurse and inves viewed the purplish hand. DON was qu area was actually b skin though confirm on the admission s Review of the skin 16:00 (4:00 p.m.) ir iv (intravenous) site (measurement was	d/wrist should have been admission skin assessment if admission or if new reported to stigated. DON and surveyor a discoloring on R123's left uestionable as whether the oruising or discoloring of the ned it should have been noted					

If continuation sheet Page 19 of 26

		AND HUMAN SERVICES				FORM	: 03/09/201 APPROVE . 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245228		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING				(X3) DATE SURVEY COMPLETED 02/06/2015	
					02/		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH BRUCE STREET MARSHALL, MN 56258				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH ROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 309	Continued From pa cm wide, old iv site When interviewed o	-	F 30)9			
	reported to the nurs when identified.	med that bruising should be se and investigated/monitored					
	Program Descriptic B. Interventions (foulcers) 5. Monitoring -	essure Ulcer Prevention on, reviewed 4/14 included: or prevention of pressure Expectations pection of skin condition is					
F 329 SS=D	supervising nurse.	ny changes in skin condition to EGIMEN IS FREE FROM IRUGS	F 32	29			3/18/15
	unnecessary drugs drug when used in duplicate therapy); without adequate m indications for its us adverse consequer	g regimen must be free from . An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of nees which indicate the dose or discontinued; or any e reasons above.					
	resident, the facility who have not used given these drugs u therapy is necessa as diagnosed and o record; and resider drugs receive grad	chensive assessment of a must ensure that residents antipsychotic drugs are not unless antipsychotic drug ry to treat a specific condition documented in the clinical ats who use antipsychotic ual dose reductions, and tions, unless clinically					

If continuation sheet Page 20 of 26

		AND HUMAN SERVICES			FORM	03/09/2019 APPROVED 0938-039
			IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245228	B. WING _		02/	06/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AVERA N	IORNINGSIDE HEIGH	ITS CARE CENTER		300 SOUTH BRUCE STREET MARSHALL, MN 56258		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
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.			 Depression screen complet identified resident. Pharmacy review completed identified resident. Behavior monitoring for iden 	for tified	
	Review of R76's hi physician dated 6/1 that included sertra milligrams (mg) dai orders dated 8/25/1 increase the sertral 50 mg daily. Review of the care	to the facility on 6/16/14. story and physical by the 6/14 indicated medications line (an antidepressant) 25 ly. Review of the physician 14, included an order to line dose from 25 mg daily to plan dated 10/17/14 included: s ad or depressed. I want to		 resident initiated upon completidepression screen, started 3/5/ 4. Facility policy on Response to Resident Behavior in LTC up will be reviewed with staff at all meeting on 3/18/15. 5. Residents with orders for psychopharmacological medicad discussed at resident's care contant discussion results forwardef facility's Behavior Management Committee for evaluation. Any recommendations for drug ordef will be communicated to staff at an antipation. 	15. Guidelines dated and staff tion will be nferences ed to er changes	
	maintain my memo declined. I have ha Continue to give the staff will watch me indicators of depres do a depression sc Review of the quar assessment dated been assessed with	ry and realize that it has ad depression in the past. e medications per order. The for changes in my mood or ssion. The social worker will		behavior monitoring will be com Follow up review of behavior monitoring will continue at subsequent Beh Management Committee meeting 6. On-going compliance with be monitoring will be completed and to LTC Quality Committee monitoring quarterly thereafter.	pleted. onitoring avior ngs. ehavior d reported	

If continuation sheet Page 21 of 26

CENTERS FOR MEDICARE & MEDICAID SERVICES		(X2) MULTIPLE CONSTRUCTION			0MB NO. 0938-039 (X3) DATE SURVEY		
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
		245228	B. WING		02/	06/2015	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
AVERA N	IORNINGSIDE HEIGH	ITS CARE CENTER		300 SOUTH BRUCE STREET MARSHALL, MN 56258			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE	
F 329	assessment dated score of "5", indica symptoms. Review of the elect R76's mood and be 6/17/14 - 6/22/14 w behaviors. The fac further evidence re mood and behavior assessments. When interviewed of director of nursing and behavior had re	llowing and most recent MDS 12/11/14 indicated a PHQ-9 ating mild depressive ronic medical record indicated ehavior was monitored from with no identified mood and sility was unable to provide lated to monitoring of R76's r other than the quarterly MDS on 2/05/2015, at 4:24 p.m. the (DON) confirmed R76's mood not been monitored following antidepressant medication	F 329				
F 425 SS=D	interview during the of pharmacy servic 2/06/2015, at 8:52 staff to be monitorin increase of an antio 483.60(a),(b) PHAF ACCURATE PROC The facility must pr drugs and biologica them under an agre §483.75(h) of this p unlicensed person	RMACEUTICAL SVC - CEDURES, RPH ovide routine and emergency als to its residents, or obtain eement described in part. The facility may permit nel to administer drugs if State ly under the general	F 425			3/18/15	

If continuation sheet Page 22 of 26

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	IPLETED
245228 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 TAGSUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)ID PREFIX TAGPROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
 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 medications record (MAR) identified R65 was to receive Lantanoprost (to control the progression of glaucoma or cular hypertension by reducing intraocular pressure) 0.005% eye drops. Not opt to each eye. TMA-A looked at the bottle and compared it to the MAR. She stated, "Ya, this is it, it is the right one, it's the only one that is in there." At that point TMA-A trom administering the incorrect 	

If continuation sheet Page 23 of 26

						. 0938-039 ⁻	
		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	245228		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	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 425 F 428 SS=D	practical nurse (LP R65's room. TMA- Lantanoprost eye d checked the medic R65 did not have a the cabinet. LPN-C drops had been dis not know why there drops available. Review of the medi 2/5/15, identified th the Lantanoprost d administered or ref During interview wi (DON) on 2/5/15, a packing slip identifi Latanoprost 0.005% The DON stated th received the medic know why the medic know why the medic chow why the medic buring interview wi on 2/6/15, at 9:15 a Latanoprost drops opening. He stated be dated when ope after opening. He v ordered was delive	se. At 7:30 p.m. licensed N)-C was asked to come to A explained that there were no drops in R65's room. LPN-C ation cabinet and confirmed ny Lantanoprost eye drops in indicated the Cosopt eye scontinued on 1/26/15, and did e were no Lantanoprost eye ication records from 9/14/14 to e facility staff were signing out rops as being either used. th the director of nursing tt 10:00 a.m. she brought a he pharmacy dated 9/3/14. The ed that the facility received % drops for R65 on that date. at was the last time the facility ation. She stated she did not ication was not reordered. th the consultant pharmacist a.m. he indicated the were good for 42 days after the Latanoprost bottle should oned and discarded 42 days rerified that the last bottle red on 9/3/14. EGIMEN REVIEW, REPORT	F 4			3/18/15	
00-0	The drug regimen of	of each resident must be nce a month by a licensed					

Facility ID: 00343

If continuation sheet Page 24 of 26

	-	AND HUMAN SERVICES					FORM	APPROVED
	<u>RS FOR MEDICARE</u> OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRU		O		0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		NG				PLETED
		245228	B WING				00/	
NAME OF	PROVIDER OR SUPPLIER	245220	D. 11110 _		RESS, CITY, STATE, Z		02/	06/2015
					BRUCE STREET	II OODE		
AVERA N	IORNINGSIDE HEIGH	ITS CARE CENTER			L, MN 56258			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF			(X5)
PRÉFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		CH CORRECTIVE ACT SS-REFERENCED TO T DEFICIENC	THE APPROPE		COMPLÉTION DATE
F 428	Continued From pa	ge 24	F 42	28				
	the attending physic	st report any irregularities to cian, and the director of reports must be acted upon.						
	by: Based on interview pharmacist failed to and behavior monit daily dose of an ant residents (R76) rev medications. Findings include: R76 was admitted t Review of R76's his physician dated 6/1 include sertraline (a milligrams (mg) dai orders dated 8/25/1 increase sertraline f Review of the care "I do not want to be maintain my memo declined. I have ha Continue to give the staff will watch me f indicators of depress do a depression sci Review of the quart	plan dated 10/17/14 included: sad or depressed. I want to ry and realize that it has d depression in the past. e medications per order. The for changes in my mood or ssion. The social worker will		identifie 2. Faci Medica with pha staff me 3. On-g regimer monitor LTC Qu	armacy review cor ed resident. lity policy on Princ tion Use updated armacy staff and eeting on March 1 going compliance n review will occu ring activity. Resu Juality Committee r a, quarterly therea	ciples of and review LTC staff a 8, 2015. with drug r through c ults reporte nonthly x 3	ved at all quality ed to	

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

If continuation sheet Page 25 of 26

PRINTED: 03/09/2015

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 03/09/2015 APPROVED : 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245228	B. WING			02/	06/2015
NAME OF	PROVIDER OR SUPPLIER		-		STREET ADDRESS, CITY, STATE, ZIP CODE		
AVERA	MORNINGSIDE HEIGH	ITS CARE CENTER			800 SOUTH BRUCE STREET MARSHALL, MN 56258		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 428	(Resident Mood Int indicating no depre following and most dated 12/11/14 indi indicating mild depre Review of the elect R76's mood and be 6/17/14 - 6/22/14 w identified. The facil further evidence re mood and behavior assessments. Review of the mont regimen reviews da 11/25/14, 12/26/14, the need for monitor related to the antidor When interviewed of director of nursing R76's mood and be completed following antidepressant med The facility pharma interview during the of pharmacy servic at 8:52 a.m. indicat	terview) with a score of "0" essive symptoms. The recent MDS assessment icated a PHQ-9 score of "5" ressive symptoms. tronic medical record indicated ehavior was monitored from vith no mood and behaviors ity was unable to provide lated to monitoring of R76's r other than the quarterly MDS thly pharmacy medication ated, 9/25/14, 10/25/14, , and 1/26/15 did not identify pring of mood and behavior epressant use. on 2/05/2015, at 4:24 p.m. the (DON) confirmed monitoring of ehavior had not been g the increase of the dication (sertraline). acist was not available for e survey. Although the director ces was interviewed on 2/6/15, ted he would expect staff to be nd behavior with the increase		428			

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

Facility ID: 00343

If continuation sheet Page 26 of 26

		AND HUMAN SERVICES F	527	28024	FORM	03/16/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING 02 - NEW BUILDING AND RENOVATED NG BLD		E SURVEY PLETED
		245228	B. WING		02/	04/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	ORNINGSIDE HEIGH	ITS CARE CENTER		300 SOUTH BRUCE STREET		
				MARSHALL, MN 56258		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		DBE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	rs	KO	000		
	FIRE SAFETY					
-	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.				
	ONSITE REVISIT O CONDUCTED TO V SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.				
	Minnesota Departm Fire Marshal Divisio the time of this surv Medical Center Nur substantial complia participation in Med Subpart 483.70(a), 2000 edition of Nati Association (NFPA)	Survey was conducted by the eent of Public Safety, State on, on February 4, 2015 At rey, Avera Marshall Regional sing Home was found not in nce with the requirements for icare/Medicaid at 42 CFR, Life Safety from Fire, and the onal Fire Protection Standard 101, Life Safety er 18 New Health Care		EPOC]	
	PLEASE RETURN CORRECTION FOI DEFICIENCIES (K-	R THE FIRE SAFETY				
2	Health Care Fire Ins State Fire Marshal I 445 Minnesota St., St. Paul, MN 55101 Facsimile: 651-215	Division Suite 145 -5145				
LABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE	TITLE		(X6) DATE
Electron	ically 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.

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

Event ID: AG4J21

Facility ID: 00343

		AND HUMAN SERVICES			FORM	03/16/201 APPROVEI 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 02 - NEW BUILDING AND RENOVATED BLD		E SURVEY PLETED
		245228	B. WING		02/0	04/2015
	PROVIDER OR SUPPLIER	HTS CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH BRUCE STREET MARSHALL, MN 56258		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	Continued From pa	age 1	K 00	0		
	By e-mail to: Marian.Whitney@s Angela.Kappenma					
		ST INCLUDE ALL OF THE				
	1. A description of to correct the defic	what has been,or will be, done iency.				
	2. The actual, or p	roposed, completion date.				
	responsible for cor	or title of the person rection and monitoring to ence of the deficiency.				
	Home was constru The original buildin two-stories in heigh fire sprinkler protect of Type II(111) cons The 2004 Addition basement, is fully f	g was constructed in 1963, it is ht, has no basement, is fully cted and was determined to be				
	hospital by 2-hour building has a fire a detection in the con automatic fire depa Additionally, all Res with automatic smo	is separated from an attached fire rated wall assemblies. The alarm system with smoke ridors, which is monitored for artment notification. sident Rooms are equipped oke detection. The facility has ds and had a census of 70 at				
		ve renovation of the original entire facility was surveyed as				

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	03/16/2015 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` '	G 02 - NEW BUILDING AND RENOVATED		E SURVEY PLETED
		245228	B. WING		02/0	04/2015
NAME OF F	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	(STREET ADDRESS, CITY, STATE, ZIP CODE		
AVERA M	IORNINGSIDE HEIGH	TS CARE CENTER		300 SOUTH BRUCE STREET MARSHALL, MN 56258		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Health Care Occup	A 101 (2000) Chapter 18 New ancies.	K 00	0		
K 143 SS=D	NOT MET as evide NFPA 101 LIFE SA	FETY CODE STANDARD	K 14	3		2/6/15
	Transferring of oxyg	jen is:		10 ži		
	wherein patients are	any portion of a facility e housed, examined, or tion of a fire barrier of 1-hour uction;		3		
		s mechanically ventilated, s ceramic or concrete flooring;				
	transferring is occur immediate area is n	d with signs indicating that rring, and that smoking in the ot permitted in accordance ne Compressed Gas 2.5.2				
	Based on observat	s not met as evidenced by: ion and interview, the facility's erring room did not meet the ordance to NFPA		Signage installed on the door of the Liquid Oxygen Transferring Room	•	
	Finding include;					
	and 1:30 PM, on 02 the Liquid Oxygen T have signage indica occurring, and that	etween the hours of 9:00 AM. /04/2015, it was observed that ransferring Room did not ting that transferring is smoking is not permitted in FPA 99 and the Compressed				

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

Event ID: AG4J21

Facility ID: 00343

If continuation sheet Page 3 of 4

ATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SU IDENTIFICATIO	IPPLIER/CLIA		IG 02 - I	NSTRUCTION	AND RENOVAT	(X3) DA). 0938-03 TE SURVEY MPLETED	
		245	228	B. WING				02	02/04/2015	
	PROVIDER OR SUPPLIER		ER		STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH BRUCE STREET MARSHALL, MN 56258					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICI Y MUST BE PRECED .SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	1	PROVIDER'S (EACH CORRE CROSS-REFERE	S PLAN OF COR	SHOULD BE	(X5) COMPLETIC DATE	
K 143	Continued From pa Gas Association.	age 3		K 14	3					
	This deficient pract Maintenence Mana		by the							



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

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

Avera Morningside Heights Care Center February 24, 2015 Page 2

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,

Kumalu Fiske Downing

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

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00343	B. WING		02/0	6/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AVERA N	IORNINGSIDE HEIGH	ITS CARE CENTE	TH BRUCE S			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defice herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ant for non-compliance.				
Ainpoceto	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal s Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware. to	
	epartment of Health 7 DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

Electronically Signed

STATE FORM

6899

If continuation sheet 1 of 27

03/09/15

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		00343	B. WING		02/0	6/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
AVERA N	ORNINGSIDE HEIGH		TH BRUCE S			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	ige 1	2 000			
	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro- completion date, th corrected prior to e Minnesota Departm On 2/2/15 - 2/6/15 staff, visited the ab- correction orders a your electronic plan reviewed these ord they will be comple Minnesota Departm the State Licensing federal software. Ta	surveyors of this Department's ove provider and the following re issued. Please indicate in of correction that you have ers, and identify the date when		The assigned tag number far left column entitled "ID The state statute/rule num corresponding text of the s out of compliance is listed "Summary Statement of D column and replaces the " portion of the correction of column also includes the are in violation of the state statement, "This Rule is n evidenced by." Following findings are the Suggester Correction and the Time F Correction. PLEASE DISREGARD TH THE FOURTH COLUMN STATES, "PROVIDER'S F CORRECTION." THIS AP FEDERAL DEFICIENCIES WILL APPEAR ON EACH	D Prefix Tag." aber and the state statute/rule in the Deficiencies" To Comply" rder. This findings which e statute after the ot met as the surveyors d Method of Period For HE HEADING OF WHICH PLAN OF PLIES TO S ONLY. THIS	
	column entitled "ID statute/rule out of o "Summary Stateme and replaces the "T correction order. Th findings which are i after the statement evidence by." Follo are the Suggested Time period for Con PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA	ARD THE HEADING OF THE		THERE IS NO REQUIRED SUBMIT A PLAN OF COP VIOLATIONS OF MINNES STATUTES/RULES.	RECTION FOR	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED
		00343	B. WING		02/06/2015
NAME OF F	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE	
AVERA N	IORNINGSIDE HEIGH	ITS CARE CENTE	TH BRUCE S		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLET DATE
2 000	Continued From pa	ge 2	2 000		
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.			
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565		3/18/15
	Subp. 3. Use. A comust be used by all care of the resident	omprehensive plan of care personnel involved in the			
	by: Based on observati review the facility fa of care related to th non-pressure related	ent is not met as evidenced on, interview, and document ailed to follow the written plan be identification of ed skin issue for 5 of 6 2, R65, R123, R25) reviewed.		Corrected	
	Findings include:				
	noted R28 had thre on the top of his lef top of his right hand	on 2/5/15, at 11:47 a.m. it was e dark purple bruises located t hand and one located on the d. R28 and family (F)-B denied or when these bruises had			
	staff would check the bedtime for red, rase and report concerns	plan dated 7/2/14, listed the ne skin in the morning and at shy or open areas or changes s to the nurses. The care plan nitoring of bruising or other es.			

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00343	B. WING		02/	06/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE	•	
AVERA N	MORNINGSIDE HEIGH	ITS CARE CENTE	TH BRUCE ST			
(X4) ID		TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLET
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	DATE
2 565	Continued From pa	age 3	2 565			
		an Orders dated 12/16/14, ived 81 milligrams (mg) Aspirin				
	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.					
	stated R28 had fall	d on 2/5/15, at 11:54 a.m. and en previously and she did not have caused the bruises or if nething else.				
		NA)-A as interviewed on n. and revealed she was not ising on his hands.				
	interviewed on 2/5/ the procedure follor identified was to no nurse (RN). The RI assessment, and fi was indicated. Duri	nurse (LPN)-C was 15, at 12:56 p.m. and stated wed when bruising was tify the charge registered N would then perform an Il out the incident report if it ng a subsequent interview on				
	aware of bruising o the bruises were pr reported to the regi assessment. LPN-0	. LPN-C stated she was not in R28's hands. LPN-C verified resent and should have been stered nurse (RN) for C measured the bruised areas. ated on R28's right hand was				
	round and measure (x) 1 cm wide. The knuckles of the 3rd hand-one bruise wa	ed 1 centimeter (cm) long by bruise was located behind the and 4th digits. On R28's left as 2.5 cm in long x 1.5 cm in				
	of the 3rd and 4th of between the knuck	as located behind the knuckles digits and covered the area les and wrist, the second and measured 1.5 cm long x				

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00343	B. WING		02/	06/2015
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE	1	
AVERA N	IORNINGSIDE HEIGI		TH BRUCE ST ALL, MN 5625			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 565	aspect of the wrist forearm. The third sized and faded. T the knuckle of the area between the t An interview was c at 3:04 p.m. RN-A any bruising on R2 staff was to notify t resident bruise or of then complete an a doctor. Following of areas on R28's had areas should have nurse, assessed a electronic record in being updated. The	age 4 bruise was located on the outer and extended onto the area was approximately dime he bruise was located behind 1st digit and extended into the humb and first digit. onducted with RN-A on 2/5/15, stated she was not aware of 8's hands. She further stated he charge nurse regarding a other injury and the RN would assessment and update the observation of the bruised nds, RN-A verified that the been reported to the charge and documented in the n addition to the physician e plan of care was not followed ag and monitoring of the curren				
	her room on 2/2/15 purple bruise was of arm. R62 could no from but stated "I p resident was also of area on the corners On 2/5/15, at 9:19 dining room. R62's rash on the corners R62 was also obse bruise just below th her right arm. R62 noticed the bruise how it occurred.	seated in her wheel chair in 5, at 4:45 p.m. A 1/2 inch dark observed on the top of her right t recall where the bruise came probably just bumped it." The observed to have a red rashy s of her mouth and on her chin a.m. R62 was sitting in the c chin continued to have a red s of her mouth and on her chin. erved to have a dark purple he bruise noted on 2/2/15 on indicated at that time that she yesterday but did not know				
nonata D	The MDS dated 11	/6/14, indicated R62 was				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00343	B. WING		02/	06/2015
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•	
AVERA I	MORNINGSIDE HEIGH	ITS CARE CENTE	TH BRUCE ST ALL, MN 56258			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	severely cognitively plan dated 11/20/14 skin conditions. Inter required to be care transferring the res bruising easily; staf in the a.m. and p.m. any redness/rash of notify the charge nu Review of the skin identified a skin irre- but did not include rash. When interviewed of household support medication aide (TI unaware of the resi or skin rash. They bi identified these skin charge nurse. When interviewed of indicated she was of right arm nor did sh rash that a.m. when indicated that all ide reported to the nurse On 2/05/2015, at 97 R62's bruises on he LPN-C indicated sh or bruises previous that an incident rep completed for any it to the RN. She also	y impaired. Review of the care 4, identified a focus topic of erventions listed; staff was ful with positioning and ident due to the resident if to check the resident's skin a. with cares and observe for or open areas. The staff should urse if concerns are identified. assessment dated 2/3/15, egularity labeled "Rash Breast. the identified bruising or facial on 2/4/15, at 2:29 p.m. staff (HSS)-A and trained MA)-A indicated they were idents bruise on the right arm both indicated if they had in issues they would notify the on 2/4/15, at 2:36 p.m. LPN-A unaware of R62's bruise on he ne notice the residents facial n observed with cares. LPN-A entified skin issues should be se. :25 a.m. LPN-C confirmed er right arm and facial rash. he had not observed the rash ly. LPN-C further included wort should have been dentified bruising and reported o stated the NA should have in issues with cares and report	r			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00343	B. WING		02/	06/2015
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		00/2010
	ORNINGSIDE HEIGH	HTS CARE CENTE 300 SOU	TH BRUCE ST	REET		
		MARSHA	ALL, MN 56258			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 565	Continued From pa	age 6	2 565			
	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.					
	recliner on 2/2/15, a observed to have a purple/red bruise o R65 identified the b	seated in her room in her at 5:28 p.m. The resident was an approximate 1.0 centimeter n the top of her right elbow. oruise occurred during the g the grab bar. She denied				
	conditions with inte skin every am and redness/rash or sk any concerns to the	d 10/30/14, included skin erventions including, staff check HS for any signs of in breakdown and will report e licensed nurses. Review of did not identify the bruising.	s.			
	The MDS dated 1/- moderate cognition	15/15, indicated R65 had n impairment.				
	stated that she did She stated she did an incident report of	on 2/5/15, at 9:57 a.m. RN-A not know about the bruise. not know if anyone filled out on the bruise or not. She also a had identified the bruise on				
	room with purplish left hand and top o the wrist on 2/3/15, identify how the bru	d seated in his recliner in his bruising noted on the top of his f his right hand extending to , at 12:20 p.m. R123 could not uising had occurred, but ve been during his recent				

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00343	B. WING		02/	06/2015
IAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST	ATE, ZIP CODE	· · · ·	
VERA N	IORNINGSIDE HEIGH	ITS CARE CENTE	TH BRUCE ST LL, MN 56258			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 7	2 565			
	1/30/15, indicated t the facility on 1/30/ focus topic of skin of included; staff will of Review of the admit 1/30/15, identified f irregularities with n documentation in the was found related the hands. When interviewed of indicated she had a	short term care plan dated the resident was admitted to 15. The care plan included a conditions. Interventions observe for bleeding/bruising. ission skin assessment dated R123 as having no skin o bruising identified. No he residents medical record to R123's bruising of the on 2/5/15, at 8:50 a.m. TMA-A assisted R123 with morning				
	right or left hand. T	notice bruising to the resident's MA-A further included when ise she is to report it to the				
	indicated she had r bruising. LPN-D ob bruising to the top o LPN-D further state was to be complete are gotten up in the	on 2/5/15, at 8:41 a.m. LPN-D not been aware of R123's served and verified R123's of the left hand and right hand. ed that inspection of the skin ed twice daily when residents e morning and put to bed at oruises should have been rted to the nurse.				
	(DON) confirmed the resident's right han addressed on the a present or if the res	p.m. the director of nursing ne large bruised area on the d/wrist should have been admission skin assessment if sident obtained the bruise after have been reported to the ated at that time.				
	When interviewed of the second	on 2/6/15, at 8:45 a.m. the				

STATEMEN	It OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00343	B. WING		02/	02/06/2015	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE	· · ·		
AVERA N	IORNINGSIDE HEIGI		TH BRUCE ST				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 565	Continued From pa	age 8	2 565				
	facility administrator confirmed R123's bruising should have been identified and reported to the nurse and investigated/monitored.						
	the knuckles of the	dark purple bruise between 4th and 5th digits and a dark e lower forearm of the right 5, at 3:27 p.m.					
	diagnosis of cerebrisided hemiparesis 11/27/14, indicated The plan of care, la R25 was at risk for bruising easily due included staff to ob and open areas in Staff were to provid they were doing an	ecord dated 5/16/05, included ral vascular accident with right (paralysis). The MDS dated R25's cognition to be intact. ast updated 12/4/14, indicated skin problems, skin tears and to immobility. Interventions oserve skin for redness, rash the morning and at bedtime. de cares slow, tell R25 what id to be careful with transfers. identify the bruises on the right	t				
	3:47 p.m. LPN-B m were 1 centimeter forearm and 1.5 cm and 5th digits on th aware of the bruise	tion and interview on 2/5/15, at neasured the bruises and they (cm) diameter on the right n by 0.6 cm between the 4th ne right hand. RN-B was not es and did not find them edical record. RN-B reported ked with the bath.					
	DON indicated that cares and concern She indicated there skin assessment. T would expect the s	v on 2/5/15, at 3:41 p.m. the t skin was to be observed with s to be reported to the nurse. e was no formal weekly nurse The DON reported that she taff to be monitoring the skin ges to the charge nurse as per					

	ota Department of He	alth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00343	B. WING		02/	06/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
AVERA N	MORNINGSIDE HEIGH	ITS CARE CENTE	TH BRUCE ST LL, MN 56258			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 9	2 565			
2 830	 Program Descriptio B. Interventions (four ulcers) 5. Monitoring - I a. Daily inspired uired. b. Report an supervising nurse. SUGGESTED MET director of nursing (develop, review, an procedures to ensurplans according to the needs. The director could educate all ag and procedures. The designee could develop could edvate all ag and procedures. The designee could develop could edvate all ag and procedures. The director could educate all ag and procedures. The designee could develop could edvate all ag and procedures. The designee could develo	THOD OF CORRECTION: The (DON) or designee could d/or revise policies and re the facility develops care the residents individualized of nursing (DON) or designee opropriate staff on the policies he director of nursing (DON) or relop monitoring systems to npliance. R CORRECTION: Twenty-one	2 830			3/18/15

Minnesc	ta Department of He	alth					
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPI IDENTIFICATION N				(X3) DATE COMP	SURVEY LETED
		00343		B. WING		02/0	6/2015
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		
AVERA N	MORNINGSIDE HEIGH	ITS CARE CENTE		TH BRUCE S			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENC / MUST BE PRECEDED E SC IDENTIFYING INFORI	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	-	videnced	2 830			
	by: Based on observati review the facility fa skin issues for 6 of R123, R5, R25) rev related skin conditio	on, interview, and on iled to identify and 6 residents (R28, rewed for non-pres	document monitor R62, R65,		Corrected		
	Findings include:						
	During an observat p.m, R28 stated he gotten the bruised a spouse stated it mig R28 grabbing onto stated she thought awhile and voiced of caused them.	didn't know how he areas on his hands ght have been caus the stand up lift. S the bruises had be	e had . R28's sed from he further en there for				
	During an observat it was noted that R2 bruises located on one on the back of	28 had three (3) da the back of his left	rk purple				
	R28 was admitted of including advanced R28's quarterly min 12/24/14 included a Status (BIMS) indic impairment. The ca skin condition would and bedtime cares or changes and rep	dementia and hea imum data set (ME a Brief Interview of ating severe cognit are plan dated 7/2/ d be monitored with for red, rashy or op	Int disease. DS) dated Mental tive 14 indicated n morning pen areas				
	When interviewed of R28's spouse state						
Minnesota D STATE FOR	epartment of Health M			6899	AG4J11	If continuatio	n sheet 11 of 27

ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00343	B. WING		02/	06/2015
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	• • •	
	IORNINGSIDE HEIG	HIS CARE CENTE	JTH BRUCE ST			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ALL, MN 5625	B PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 830	Continued From page 11		2 830			
	had caused the bro R28's spouse also any additional brui occurred. When interviewed nursing assistant (e didn't know whether the fall uises or what had happened. stated she was not aware of ses or injuries that had on 02/05/15, at 12:09 p.m. NA)-A stated she was not d bruising on the back of his				
	licensed practical of procedure followed was to notify the cl The RN would the fill out the incident During a subseque p.m. LPN-C stated on R28's hands. L present and should for assessment. L areas. The bruise was round and me by (x) 1 cm wide. the knuckles of the left hand-one bruis cm in wide. This b knucles of the 3rd area between the l bruise on the left h 1.5 cm wide. This	on 02/05/15, at 12:56 p.m. hurse (LPN)-C stated the d when bruising was identified harge registered nurse (RN). n perform an assessment, and report if it was indicated. ent interview on 2/5/15, at 2:35 I she was not aware of bruising PN-C verified the bruises were d have been reported to the RN PN-C measured the bruised located on R28's right hand easured 1 centimeter (cm) long The bruise was located behind easd and 4th digits. On R28's se was 2.5 cm in long x 1.5 bruise was located behind the and 4th digits and covered the knuckles and wrist , the second and measured 1.5 cm long x bruise was located on the				
	forearm. The third sized and faded. the knuckle of the area between the	e wrist and extended onto the l area was approximately dime This bruise was located behind 1st digit and extended into the thumb and first digit. on 2/05/15, at 3:04 p.m. RN-A	ł			

STATEMEN	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00343	B. WING		02/	06/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
VERA N	ORNINGSIDE HEIGH	ITS CARE CENTE	TH BRUCE ST ALL, MN 56258			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	ige 12	2 830			
	presence of the bru should have been r further stated depe injury an incident re	ands. RN-A verified the lises and further indicated they reported and assessed. RN-A nding on the size and type of eport would be filed or it might the nursing progress notes ort.				
	director of nursing of reports were not ro The DON further in then a formal assess the instance of a la	on 2/5/15 at 3:40 p.m. the (DON) stated that incident utinely completed for bruises. Indicated if an area was small ssment was not necessary. In rge area or unknown cause onitored daily and the physiciar on treatment.				
	in her wheel chair in purple bruise was r arm. R62 could no came from but state just bumped it." Als R62's mouth and he rashy. On 2/5/15, a in the dining room a a pink rash and the red and irritated (sk Another dark purple located just below t	o.m. R62 was observed seated in her room. A 1/2 inch dark noted to the top of her right t identify where the bruise ed no one hurt her, "I probably so noted that the corners of er chin were very red and at 9:19 a.m. R62 was seated and her chin continued to have corners of her mouth were kin crease's around chin). be bruise was noted and was the one noted on 2/2/15 on her red she got that yesterday and coccurred.				
	conditions with inte easily and the bruis time, staff need to b transferring and the and HS [bedtime] for	d 11/20/15 included skin rventions including: bruises ses do not go away in a short be careful with positioning and e staff checks R62's skin a.m or any redness/rash or open e licensed nurses of any				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00343	B. WING		02/	06/2015
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
VERA N	ORNINGSIDE HEIGH	ITS CARE CENTE	TH BRUCE ST ALL, MN 56258			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 13	2 830			
i	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."					
	household support medication aide (T	on 2/4/15, at 2:29 p.m. staff (HSS)-A and trained MA)-A stated if they discovered ith a resident they would let the v about it.				
	stated she had not morning she didn't rashy. LPN-A state R62 was in activitie	on 2/4/15, at 2:36 p.m. LPN-A seen any bruise and that this notice that R62's face was ed she would check it later as es. She stated that if any new ue is found it should be se.				
	observed R62 in th she had not seen She stated an incic for any bruising and nurse (RN). She al	5 a.m. surveyor and LPN-C e dining room. LPN-C stated the rash or bruises previously. lent report should be filled out d reported to the registered so stated the aides are any areas of bruising or skin rse.				
	stated she didn't kr being filled out abo that maybe the LPI stated either herse to fill out the incide	on 2/5/15 at 9:30 a.m. RN-A now of any incident reports ut bruises on R62. She stated N had filled one out. She If or the LPN were responsible nt reports. RN-A was unable to o of the skin issues in the				
	in her room in her i	p.m. R65 was observed seated recliner. An approximate 1 ed bruise was noted on the top				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00343	B. WING		02/	06/2015
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
VERAN	IORNINGSIDE HEIGH		TH BRUCE ST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 830	Continued From pa	age 14	2 830			
	bruise occurred du	v. R65 identified that the ring the night from bumping denied anyone hurting her.				
	conditions with inter skin every am and redness/rash or ski any concerns to the the medical record	d 10/30/14 included skin rventions including, staff check HS for any signs of in breakdown and will report e licensed nurses. Review of did not identify the bruising. nilligrams of aspirin everyday.				
	stated that she did She stated she did	on 2/5/15, at 9:57 a.m. RN-A not know about the bruise. not know if anyone filled out on the bruise or whether the entified.				
	noted R5's right ha cracked along the l fingers. R5 reported her hands all her lift	ion on 2/6/15, at 8:11 a.m. nd to be dry, rough and knuckle areas of all five d that she has had trouble with e and sometimes they would that she tries to put lotion on				
	of 8/1/05 and diagr and history of press sores. Documenta (MDS) dated 12/3/1 for mental status (E moderate cognitive (POC) last updated a risk for skin breat vascular disease, c and stasis ulcer/so	d indicated an admission date noses to include osteoporosis sure and stasis ulcers or ation on the minimum data set 14, indicated the brief interview BIMS) of R5 identified function. The plan of care 16/16/14 indicated that R5 had kdown due to peripheral liabetes, and also for pressure res. Interventions indicated				
	daily for skin chang	eck R5's legs, feet and heels les and notify the RN The POC indicated that skin				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00343	B. WING		02/	06/2015
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
VERAN	IORNINGSIDE HEIGH	HIS CARE CENTE	TH BRUCE ST ALL, MN 56258			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 15	2 830			
	they would notify th concerns. The reco	weekly at bath time and that he nurse if there were any ord did not identify the dry, condition of R5's right hand.				
	the licensed practic that there were no LPN-A inspected th the skin was dry, ro attention. LPN-A in assessments on ac assessments on cu	v on 2/6/15, at 8:25 a.m. with cal nurse (LPN)- A indicated skin concerns with R5's hands he right hand and verified that bugh and cracked and needed dicated the RN conducts skin dmission, conduct weekly urrently identified wound and I staff were to report any se.				
	noted R25 had a da knuckles of the 4th	tion on 2/5/15, at 3:27 p.m. ark purple bruise between the and 5th digits on the right urple bruise on the lower the extremity.				
	diagnoses which in accident with right s The MDS dated 11, cognition to be inta 12/4/14, indicated t problems, skin tear immobility. Interve observe skin for re- the morning and at cares slow, tell R25 be careful with tran	d indicated that R25 had icluded cerebral vascular sided hemiparesis (paralysis). /27/14, the BIMS indicated ct. The POC, last updated that R25 is at risk for skin rs and bruised easily due to ntions included staff to dness, rash and open areas in bedtime. Staff were to provide 5 what they were doing and to isfers. The record did not on the right hand and forearm				
	3:47 p.m. LPN-B v measured 1 centim	tion/ interview on 2/5/15, at rerified R25's bruises neter (cm) diameter on the righ n by 0.6 cm between the 4th	t			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00343	B. WING		02/	06/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
VERA N	IORNINGSIDE HEIGH	HIS CARE CENTE	TH BRUCE ST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 16	2 830			
	aware of the bruise identified in the me that R25's skin sho with the bath. During an interview director of nursing to be observed with reported to the nurs	te right hand. LPN-B was not es and did not find them edical record. LPN-B reported build have been checked weekly of on 2/5/15, at 3:41 p.m. the (DON) indicated that skin was in cares and any concerns se. She further indicated there kly skin assessment jurse.	,			
	seated in his reclin bruising noted to th of his right hand ex could not identify h though stated it ma) p.m. R123 was observed er in his room with purplish he top of his left hand and top stending to the wrist. R123 ow the bruising had occurred ay have been while he was b further confirmed the bruising abuse.				
	identified on the sh 1/30/15. The short conditions with inte observe for bleedin	to the facility on 1/30/15 as ort term care plan dated term care plan included skin erventions including: staff will ng/bruising. The skin 1/30/15 indicated: no skin				
	household support medication aide (T	on 2/4/15, at 2:29 p.m. staff (HSS)-A and trained MA)-A stated if they discovered ith a resident they would let the v about it.				
	licensed practical r new skin issue is ic	on 2/5/15, at 8:41 a.m. hurse (LPN)-D stated when a dentified the staff are to report hen reported to an LPN the				

-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00343	B. WING		02/	06/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	-	
	IORNINGSIDE HEIGH		TH BRUCE ST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	complete the initial R123's electronic re documentation that LPN-D then observe of the left hand and confirmed it should indicated she would assessment. LPN- inspection of the sk daily when resident and put to bed at n that R123's bath da When interviewed of confirmed she had cares that day and resident's right han TMA-A further state something out of th skin she would noti	ify the registered nurse (RN) to assessment. LPN-D reviewed ecord and could not find bruising had been identified. red R123's bruising to the top right hand/wrist and have been reported. LPN-D d notify the RN to complete an D further stated that in is to be completed twice as are gotten up in the morning ight. LPN-D also confirmed ay is on Tuesdays. Dn 2/5/15, at 8:50 a.m. TMA-A assisted R123 with morning did not notice bruising to the d/wrist or top of left hand. ed that when she notices ne ordinary with a resident's				
	director of nursing assessment is perf admission. Direct of cares and also on h changes to nursing bruising an inciden unless it is a large determine how the	(DON) stated a full body ormed by the nurse upon care staff monitor skin with bath day and will report if observed. DON stated with t report is not completed area or if staff cannot				
	observed R123 lyin The DON confirme resident's right han addressed on the a present at time of a the nurse and invest	g on his back in his room. d the large bruised area on the d/wrist should have been admission skin assessment if admission or if new reported to stigated. DON and surveyor d discoloring on R123's left				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00343	B. WING		02/	06/2015
IAME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE			
	ORNINGSIDE HEIGH	TS CARE CENTE 300 SOU	TH BRUCE ST	REET		
		MARSHA	ALL, MN 56258			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 18	2 830			
	area was actually b	uestionable as whether the pruising or discoloring of the ned it should have been noted kin assessment				
	16:00 (4:00 p.m.) ir iv (intravenous) site (measurement was	assessment dated $2/5/15$ at ncluded: bruise right hand, old e, bruising 4 x (by) 3 s not identified as inches or e left hand, 2.0 cm long x 2.0 brown.				
	administrator confir	on 2/6/15, at 8:45 a.m. med that bruising should be se and investigated/monitored				
	Program Description B. Interventions (for ulcers) 5. Monitoring - a. Daily insp required.	ressure Ulcer Prevention on, reviewed 4/14 included: or prevention of pressure Expectations pection of skin condition is ny changes in skin condition to				
	supervising nurse.		,			
	The director of nurs educate all licensed non-pressure skin of skin conditions pres admission to the fa	THOD OF CORRECTION: sing, or designee, could d staff on the need to monitor conditions and/or non-pressure sent on residents upon cility. The director of nursing udit to monitor staff e policy.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One				

	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3)	DATE SURVEY COMPLETED		
		00343	B. WING		02/06/2015		
NAME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
		300 SOU	TH BRUCE S				
	IORNINGSIDE HEIGH	MARSHA	LL, MN 562	58			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)			
21525	Continued From pa	age 19	21525				
21525	MN Rule 4658.130 Consultation	5 A.B.C Pharmacist Service	21525		3/18/15		
	Board of Pharmacy A. provides con provision of pharma home; B. establishes and disposition of a detail to enable an C. determines	nsultation on all aspects of the acy services in the nursing a system of records of receipt all controlled drugs in sufficient accurate reconciliation; and that drug records are ned and that an account of all					
	by: Based on observat review the facility fa were available to re	ent is not met as evidenced ion interview and document ailed to assure medications esidents in a timely manner for R65) who was observed during		Corrected			
	Findings include:						
	2/2/15 at 7:00 p.m. (TMA)-A was obser R65. The medication identified R65 was 0.005% eye drops, removed a bottle of from R65's medicat the bottle and comp stated, "ya, this is in one that is in there	of the medication pass on trained medication aide rved to set up medications for on administration record (MAR) to receive Lantanoprost one drop to each eye. TMA-A f eye drops labeled Cosopt tion cabinet. TMA-A looked at pared it to the MAR. She t, it's the right one, it's the only ". At this point TMA-A was Cosopt eye drops in to R65's					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00343	B. WING		02 /	06/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
	IORNINGSIDE HEIGH		TH BRUCE ST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
21525		age 20 ncorrect medication. TMA-A needed to check with the	21525			
	nurse. At 7:30 p.m. (LPN)-C was asked TMA-A explained they eye drops in R65's medication cabinet have any Lantanop LPN-C indicated the discontinued on 1/2	licensed practical nurse d to come to R65's room. nat there were no Lantanopros room. LPN-C checked the and confirmed R65 did not rost eye drops in the cabinet. e Cosopt eye drops had been 26/15, and did not know why anoprost eye drops available.	t			
	2/5/15 identified the	ication records from 9/14/14 to e facility staff were signing out rops as being either used.				
	(DON) on 2/5/15 at packing slip from the The packing slip id received Latanopro- that date. The DON time the facility received	th the director of nursing 10:00 a.m. she brought a ne pharmacy dated 9/3/14. entified that the facility ost 0.005% drops for R65 on I stated that this was the last eived the medication. She know why the medication was				
	on 2/6/15, at 9:15 a Latanoprost drops opening. He stated be dated when ope	th the consultant pharmacist a.m. he indicated the were good for 42 days after the Latanoprost bottle should ened and discarded 42 days erified that the last bottle red on 9/3/14.				
	The director of nurs Pharmacist could e eye drop expiration	THOD OF CORRECTION: sing (DON) and the Consulting establish a system to monitor dates and ensure there is a urses on documentation and				

STATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		e survey IPleted
		00343	B. WING		02/	06/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
AVERA I	MORNINGSIDE HEIGH	ITS CARE CENTE	TH BRUCE ST			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
21525	Continued From pa	ge 21	21525			
		iration dates. The DON could system and report audits to ce committee.				
	TIME PERIOD OF (14) days.	CORRECTION: Fourteen				
21530	MN Rule 4658.1310) A.B.C Drug Regimen Review	21530			3/18/15
	reviewed at least m currently licensed b This review must be Appendix N of the S Surveyor Procedure Requirements in Lo the Department of H Health Care Financ This standard is ind available through th system. It is not su B. The pharma irregularities to the and the attending p must be acted upor physician visit, or so pharmacist. For pu upon" means the ac report and the signi of nursing services C. If the attend with the pharmacist not provide adequa pharmacist believes being adversely affer refer the matter to t if the medical direct physician. If the medical	en of each resident must be onthly by a pharmacist y the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service ong-Term Care, published by Health and Human Services, sing Administration, April 1992. corporated by reference. It is ne Minitex interlibrary loan bject to frequent change. cist must report any director of nursing services hysician, and these reports n by the time of the next boner, if indicated by the irposes of this part, "acted cceptance or rejection of the ng or initialing by the director and the attending physician. ing physician does not concur i's recommendation, or does te justification, and the s the resident's quality of life is ected, the pharmacist must he medical director for review tor is not the attending edical director determines that cian does not have adequate				

AVERA MORNINGSIDE HEIGHTS CARE CENTE 300 SOU MARSH. (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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		STATE, ZIP CODE STREET	2/06/2015
AVERA MORNINGSIDE HEIGHTS CARE CENTE 300 SOU MARSH. (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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	TH BRUCE S ALL, MN 562 ID PREFIX TAG	STATE, ZIP CODE STREET 258 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETI
(X4) ID PREFIX TAGSUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)21530Continued 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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLET
justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality	21530		
 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 		Corrected	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00343	B. WING		02/	06/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	IORNINGSIDE HEIGH	ITS CARE CENTE	TH BRUCE ST ALL, MN 56258			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	age 23	21530			
	indicating no depre following and most	rerview) with a score of "0" ssive symptoms. The recent MDS assessment cated a PHQ-9 score of "5" ressive symptoms.				
	R76's mood and be 6/17/14 - 6/22/14 w identified. The facil further evidence re	ronic medical record indicated ehavior was monitored from <i>i</i> th no mood and behaviors ity was unable to provide lated to monitoring of R76's r other than the quarterly MDS				
	regimen reviews da 11/25/14, 12/26/14	thly pharmacy medication ated, 9/25/14, 10/25/14, , and 1/26/15 did not identify pring of mood and behavior epressant use.				
	director of nursing R76's mood and be completed following	on 2/05/2015, at 4:24 p.m. the (DON) confirmed monitoring o ehavior had not been g the increase of the dication (sertraline).	f			
	interview during the of pharmacy servic 2/06/2015, at 8:52	cist was not available for e survey. Although the director es was interviewed on a.m. indicated he would expec ng mood and behavior with the depressant.				
	facility could develor mood and behavior after a change in a behavior managem conducted and rep	THOD OF CORRECTION: The op a system to ensure that r monitoring is documented medication dose ordered for nent. An audit could be orted to the quality assurance re implementation has	•			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Multiple A. Building:			E SURVEY IPLETED
		00343	B. WING		02 /	/06/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	IORNINGSIDE HEIGH	ITS CARE CENTE	H BRUCE ST L, MN 5625			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
21530	Continued From pa	ige 24	21530			
	occurred.					
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty -one				
21540	MN Rule 4658.131 Usage; Monitoring	5 Subp. 2 Unnecessary Drug	21540			3/18/15
	monitor each reside unnecessary drug u home's policies and pharmacist must re- resident's attending physician does not home's recommend adequate justification believes the reside adversely affected, matter to the medical director is the medical director is the medical director physician does not the order and if the change the order, t review to the Qualit (QAA) committee r	g. A nursing home must ent's drug regimen for usage, based on the nursing d procedures, and the port any irregularity to the g physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist nt's quality of life is being the pharmacist must refer the cal director for review if the not the attending physician. If r determines that the attending have adequate justification for attending physician does not he matter must be referred for ty Assurance and Assessment equired by part 4658.0070. If ician is the medical director, macist shall refer the matter				
	by: Based on interview facility failed to ade and behavior respo	ent is not met as evidenced and document review the quately monitor resident mood onse following an increased e for 1 of 5 residents (R76) ossant modications		Corrected		

Minneso	ta Department of H	ealth			FORM APPROVE
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		00343	B. WING		02/06/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE	
AVERA N	ORNINGSIDE HEIGI	HIS CARE CENTE	TH BRUCE ST ALL, MN 5625		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLETE
21540	Continued From pa	age 25	21540		
	Findings include:				
	Review of R76's h physician dated 6/ that included sertra milligrams (mg) da orders dated 8/25/ increase the sertra 50 mg daily. Review of the care "I do not want to be maintain my memo declined. I have ha Continue to give th staff will watch me	to the facility on 6/16/14. istory and physical by the 16/14 indicated medications aline (an antidepressant) 25 ily. Review of the physician 14, included an order to line dose from 25 mg daily to e plan dated 10/17/14 included: e sad or depressed. I want to bry and realize that it has ad depression in the past. the medications per order. The for changes in my mood or ssion. The social worker will creen quarterly."			
	assessment dated been assessed wit Interview) score of symptoms. The fo assessment dated	terly minimum data set (MDS) 9/20/14 indicated that R76 had h a PHQ-9 (Resident Mood "0", indicating no depressive llowing and most recent MDS 12/11/14 indicated a PHQ-9 ating mild depressive			
	R76's mood and b 6/17/14 - 6/22/14 v behaviors. The fac further evidence re	tronic medical record indicated ehavior was monitored from vith no identified mood and cility was unable to provide elated to monitoring of R76's r other than the quarterly MDS			
nnesota D		on 2/05/2015, at 4:24 p.m. the (DON) confirmed R76's mood			
ATE FOR			⁶⁸⁹⁹ A	G4J11	If continuation sheet 26 of

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00343	B. WING		02/	06/2015	
AME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE				
	IORNINGSIDE HEIGI	HIS CARE CENTE	TH BRUCE ST ALL, MN 56258				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21540	Continued From pa	age 26	21540				
		not been monitored following antidepressant medication 5/14.					
	interview during the of pharmacy servic 2/06/2015, at 8:52	acist was not available for e survey. Although the director ces was interviewed on a.m. indicated he would expec ng mood and behavior with the depressant.	t				
	The director of nur- assure that policies and that staff traini assure each reside monitored and that unnecessary drugs developed to monit involvement of the	THOD OF CORRECTION: sing and or designee could s and procedures are updated ng has been completed to ent's drug regimen is residents are not taking s. An auditing tool could be tor compliance, with facility's consultant ure ongoing compliance.					
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty -one	;				