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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: AWWF

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

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/03/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Kathleen Lucas, Unit Supervisor 03/03/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 03/27/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 03/28/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/15/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245473
March 27, 2017

Ms. Deborah Barnes, Administrator
Oak Terrace Health Care Center
640 Third Street
Gaylord, MN 55334

Dear Ms. Barnes:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective March 1, 2017 the above facility is certified for or recommended for:

46 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 46 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 24, 2017

Ms. Deborah Barnes, Administrator
Oak Terrace Health Care Center
640 Third Street
Gaylord, MN 55334

RE: Project Number S5473027

Dear Ms. Barnes:

On January 20, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 5, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On March 3, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 9, 2017 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 January 5, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 1, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 5, 2017, effective March 1, 2017 and therefore remedies outlined in our letter to you dated January 20, 2017, 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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245473 Y1	A. Building B. Wing Y2	3/3/2017 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0329	Correction	ID Prefix F0334	Correction	ID Prefix F0428	Correction
Reg. # 483.45(d)(e)(1)-(2)	Completed	Reg. # 483.80(d)(1)(2)	Completed	Reg. # 483.45(c)(1)(3)-(5)	Completed
LSC	02/15/2017	LSC	03/01/2017	LSC	02/15/2017
ID Prefix F0441	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	03/01/2017	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) KL/KJ	DATE 03/24/2017	SIGNATURE OF SURVEYOR 38202	DATE 03/03/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON
1/5/2017

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245473	A. Building 01 - MAIN BUILDING 01 B. Wing	2/9/2017

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0353	Correction Completed 02/07/2017	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)** TL/KJ	**DATE** 03/24/2017	**SIGNATURE OF SURVEYOR** 24764	**DATE** 02/09/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 1/5/2017	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: AWWF

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

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

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

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

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/05/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **46** (L18)
13.Total Certified Beds **46** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Annette Truebenbach, HFE NE II 02/02/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 02/14/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 02/14/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 20, 2017

Ms. Deborah Barnes, Administrator
Oak Terrace Health Care Center
640 Third Street
Gaylord, MN 55334

RE: Project Number S5473027

Dear Ms. Barnes:

On January 5, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343 Fax: (320) 223-7348

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 February 14, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by February 14, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

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

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

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

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

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

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by April 5, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 5, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245473	A. BUILDING _____ B. WING _____	01/05/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 1/3/17 to 1/5/17, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). Oak Terrace Health Care Center was found to not be in compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 329 SS=D	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or	F 329		2/15/17

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

Electronically Signed | 01/30/2017

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

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	245473	A. BUILDING _____ B. WING _____	01/05/2017

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F 329	Continued From page 1 (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the physician tapered the dosage or provided justification for continued use of an antidepressant for 1 of 5 residents (R26). In addition, the facility failed to ensure side effect and efficacy monitoring was provided for antidepressant use for 1 of 5 residents (R31) reviewed for unnecessary medications. Findings include: R26's quarterly Minimum Data Set (MDS) dated 12/17/16, indicated R26 was cognitively intact with a mood screening score of two, indicating minimal depression. The MDS also identified a diagnosis of depression and indicated that R26 was taking an antidepressant. R26's physician orders dated 11/17/16, with an original order date of 3/26/12, directed staff to administer Zoloft (antidepressant) 50 milligrams (mg) by mouth (po) daily for a major depressive episode. R26's care plan dated 7/4/16, indicated R26 was taking Zoloft 50 mg daily. The care plan indicated a monthly review by the pharmacist was completed, however, did not address tapering or justification of continued use.	F 329	Corrective action for resident 26. Resident was evaluated on 1/27/17 by nurse practitioner for tapering dose reduction of antidepressant. Resident 26 decreased from 50mg Zoloft to 25mg. Side effect and efficacy monitoring for residents receiving antipsychotics will be documented in the resident TAR daily. DON will train staff by 2/15/17. DON will create an excel spreadsheet indicating the individual residents, type of antipsychotic drug, dose, date started, date reviewed by pharmacy (to ensure tapering or justification of dose), date reviewed by PCP (to track 6 month intervals), PHQ9 score, dose change and DON initials. DON will be responsible for incorporating and reviewing weekly at IDT meetings. To ensure proper follow through and effectiveness, DON and Social Services will meet monthly to discuss the process and efficacy for 3 months. Thus will then be incorporated into our QA quarterly meetings by DON to continually monitor antipsychotics. Corrective action for resident 31. Sleep monitoring is documented on TAR for each shift as of 1/30/17. As of 2/15/17, sleep monitoring will be in effect for ALL residents and charted on	

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F 329	Continued From page 2 R26's medical record did not indicate a dose reduction for the Zoloft was attempted or a justification of use was given by R26's physician for continued use. During interview on 1/4/16, at 2:21 p.m. nursing assistant (NA)-B stated that R26 regularly participated in activities and never was depressed. During interview on 1/5/16, at 8:55 a.m. R26 stated although she wanted to go home she was not sad and was happy. She also stated she had never been depressed. During interview on 1/5/17, at 1:21 p.m. registered nurse (RN)-A stated R26 had not had a taper since 3/26/12 or justification of continued use for Zoloft from the physician. During interview on 1/5/17, at 1:30 p.m. the director of nursing (DON) stated tapering and justification of use should be done according to the requirements. R31's quarterly MDS dated 11/8/16, indicated R31 had severe cognitive impairment with a staff mood screening score of zero, indicating no depression. The MDS also identified diagnoses of an anxiety disorder and psychosis and was taking an antidepressant. R31's physician orders dated 1/3/17, with an original order date of 5/26/16, directed staff to administer trazodone (antidepressant used for sleep) 100 mg via g-tube at bedtime for psychophysiologic insomnia. R31's care plan dated 5/21/15, directed staff to	F 329	PCC. DON will train staff on policy and procedures by 2/15/17. Spreadsheet will be made for all residents indicating sleep medication (Y/N) name of medication, dose, start and end dates, scheduled time of administration, number of hours slept at NOC, and other sleep (naps), side effects, effective (Y/N) to be filled out by charge nurse. NDS nurse to review weekly. DON will be responsible for incorporating and reviewing weekly at IDT meetings. To ensure proper follow through and effectiveness, DON will review monthly to discuss process and efficacy for 3 months. Sleep monitoring will also be incorporated into our QA Quarterly meetings by DON to continually monitor sleep.	

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F 329	Continued From page 3	F 329		

administer trazodone every night for sleeplessness and to monitor for any adverse side effects. The care plan did not direct staff to monitor for hours of sleep.

R31's medical record did not indicate sleep monitoring was done periodically or if R31 was having any side effects of the trazodone.

During observation on 1/4/17, at 2:06 p.m. R31 was observed to be sleeping in her wheelchair in the common area near the nursing desk.

During interview on 1/5/17, at 9:17 a.m. licensed practical nurse (LPN)-A stated they did not regularly document that R31 did not have any side effects or monitor for hours of sleep.

During interview on 1/5/17, at 12:11 p.m. the DON stated the process for tracking potential side effects was by a task in the electronic record or in the quarterly charting. The DON further stated R31 did not have a task set up for the nurses to monitor for side effect or document there were no side effects noted in the quarterly charting. The DON stated the current system for sleep monitoring was verbally from shift to shift and there was no indication in R31's medical record that R31's sleep had been monitored.

The facility policy Psychotropic Medications- Use Of dated 1/12, indicated "Side effects will be observed on a daily basis with medication administration with documentation of side effect monitoring at a minimum-monthly. Residents receiving psychotropic medications will have a gradual dose reduction attempted unless clinically contraindicated with appropriate documentation by the MD."

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F 329	Continued From page 4 The facility policy Sleep Monitoring dated 7/5/12, indicated "Residents will be rounded on hourly during the night shift by the nursing staff to ensure that residents receives a restful nights sleep. Report to the physician any resident having difficulties on a regular basis sleeping." The policy did not address how the facility would monitor sleep periodically for residents taking medications to assist with sleep.	F 329		
F 334 SS=D	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits	F 334		3/1/17

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F 334	Continued From page 5 and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.	F 334		

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F 334	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement the Center for Disease Control (CDC) guidelines for pneumococcal conjugate vaccine (PCV13) for 1 of 5 residents (R8) whose vaccination histories were reviewed. Findings include: The CDC identified adults ages 65 and older who have not previously had PCV13 and who have received at least one previous dose of pneumococcal polysaccharide (PPSV23) should receive a dose of PCV13. The dose of PCV13 should be given at least one year after receipt of the most recent PPSV23 dose. R8's record indicated, based on age, that R8 met the CDC guidelines for receiving PCV13. R8's immunization history indicated R8 had a Pneumovax vaccine dose given 11/17/94. The dose on 11/17/94 did not specify the specific type of vaccine that was administered. There was no indication R8 was offered a dose of PCV13. During interview on 1/5/17, at 11:30 a.m. the adminsistrative assistant stated she had the CDC guidelines for pneumococcal vaccines. The administrative assistant stated the facility was in process of reviewing all resident records to determine pneumococcal vaccine histories, but had not yet established a system to complete the task. The facility policy titled, Pneumococcal Conjugate (PCV13) Immunization, dated 6/12, indicated all residents will be offered pneumococcal conjugate vaccine unless medically contraindicated per CDC guidelines.	F 334	Corrective action regarding PCV13 immunization. Medical records to send consent letter on 2/1/17 for vaccination to resident representatives for authorization of PCV13 immunization administration. Upon return of authorization, all current residents will first be educated on vaccine and then vaccinated per CDC guidelines by 3/1/17 by DON or designated charge nurse. Vaccination will be charted in resident's medical records (PCC) at the time of administration by nurse giving the injection. PCV13 will be added to facility standing orders and thereafter administered upon admission by 2/15/17. DON will train staff on policy and procedures by 2/15/17. This process will be reviewed monthly by DON and tracked on a spread sheet for 3 months. DON will also incorporate data as it is received into our Infection Control Project by 3/1/17. Data will be reviewed and tracked on a spreadsheet and incorporated into our Quality Assurance meeting quarterly by DON. Our first QA meeting for 2017 is in April of 2017.	
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	F 428		2/15/17

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F 428	Continued From page 7 c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending	F 428		

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F 428	Continued From page 8 physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the pharmacist recommend the physician taper the dosage or provide justification for continued use of an antidepressant for 1 of 5 residents (R26). Findings include: R26's quarterly Minimum Data Set (MDS) dated 12/17/16, indicated R26 was cognitively intact with a mood screening score of two, indicating minimal depression . The MDS also identified a diagnosis of depression and indicated R26 was taking an antidepressant. R26's physician orders dated 11/17/16, with an original order date of 3/26/12, directed staff to administer Zoloft (antidepressant) 50 milligrams (mg) by mouth (po) daily for a major depressive episode. R26's Medication Regimen Reviews dated 1/26/16, 2/23/16, 3/16/16, 4/19/16, 5/18/16, 6/7/16, 7/19/16, 8/22/16, 9/13/16, 10/25/16, 11/22/16, and 12/19/16, indicated no medication irregularities to be addressed by the facility or physician.	F 428	Corrective action regarding Drug Regimen Review. DON will meet monthly with pharmacist to review resident's drug regimen for all residents prescribed anti-psychotics, anti-depressants, anti-anxiety, and hypnotic medications to ensure gradual dose reduction beginning the month of February 2017. This will be done on a monthly basis. Residents will be reviewed and recommendations will be forwarded to residents PCP and documented in resident's medical records. DON will train staff on policy and procedures by 2/15/17. DON will be incorporating this into the quarterly QA meetings. The efficacy and efficiency of this process will be evaluated monthly for 3 months. Then once every 6 months for a period of one year.	

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F 428	Continued From page 9 During interview on 1/5/17, at 1:21 p.m. registered nurse (RN)-A stated the pharmacist did not recommend a tapering of the Zoloft or a justification for continued use, as R26 had elevated mood scores indicating depression symptoms. RN-A stated that the pharmacist was planning on reviewing the Zoloft during his visit in January. During telephone interview on 1/5/17, at 1:22 p.m. the consulting pharmacist (CP) stated that he did not recommend, to the physician, a tapering of the Zoloft or justification for continued use, as R26 had elevated mood scores in two quarters over the last year and his assessment was that the dose should continue as ordered. The CP further stated "I certainly don't practice that way, I don't try and bother physicians with that [dose reduction/ justification of continued use], if we can see it." During interview on 1/5/17, at 1:30 p.m. the director of nursing (DON) stated tapering and justification of use should be done according to the requirements. The facility policy Psychotropic Medications- Use Of dated 1/12, indicated "Residents receiving psychotropic medications will have a gradual dose reduction attempted unless clinically contraindicated with appropriate documentation by the MD."	F 428		
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program.	F 441		3/1/17

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F 441	Continued From page 10 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the	F 441		

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F 441	Continued From page 11 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to to develop an infection control program which included trending and analysis of residents infection control data to reduce the risk of spread of infection to other residents in the facility. This had the potential to affect 42 of 42 residents who resided in the facility. Findings Include: A spreadsheet printout titled, Resident Infection, was provided by the director of nursing (DON).The columns across the spreadsheet were titled: Date ABX [antibiotics] started, Date ABX ended, Date discontinued, Criteria/site of	F 441	Corrective action regarding Infection Prevention and Control Program. We are currently using our IPCP as part of our QAPI initiative to ensure we are meeting the highest quality standards. As of 1/23/17, we have updated our TB policy for new employees. New procedure put in place to assure that all new employees receive 2 step mantoux prior to starting. DON will train staff on policy and procedures by 2/15/17. To ensure proper follow through and effectiveness, DON will review monthly to discuss process and efficacy for 3 months. Thereafter, DON will incorporate	

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F 441	Continued From page 12 infection,Culture done?,Culture results, ABX used, Resident outcome. The data entered was a monthly listing dated from January 2016 through December 2016. The data was reviewed for October 2016 through December 2016. There were eight infections entered for October 2016. The entries in the criteria/site of infection column included: - one C-diff (clostridium difficile) a bacteria - four urinary tract infections - one cellulitis - one tooth abscess - one respiratory infection There was an antibiotic listed for each entry. The report lacked the signs and symptoms, the date of onset, and the resident room numbers. It also lacked a determination if the infections were community acquired or facilty acquired. The data column for culture and residents outcome were blank. There were 10 infections entered for November 2016. The entries in the criteria/site of infection column included: - two coughs - one pneumonia - one cellulitis - four urinary tract infections. Documented on two of the entries, a question mark was listed as the site of infection. There was an antibiotic listed for each entry. The report lacked the signs and symptoms, the date of onset, and the resident room numbers. It also lacked a determination if the infections were	F 441	into our quarterly QA meetings. Infection control committee will be developed by 3/1/17 and meet ongoing on a monthly basis. As of 2/1/17 we will have implemented an ongoing infection control and prevention program for residents, staff and visitors. We have currently implemented our foam in foam out program. Dispensers have been installed at entrances with masks, hand sanitizers and Kleenexes. We have also implemented the use of over the door isolation precaution kits for infected residents. By 2/15/17, DON will have created a weekly spreadsheet to monitor residents more closely. Spreadsheet will consist of date, shifts, resident name, room number, wing, signs/symptoms, treatment by doctor and date of treatment, diagnosis, antibiotic and length, culture, caregivers, precautions (Y/N), isolation (Y/N). This will be completed for each shift by charge nurse. DON will review daily. Employee spreadsheet will also include date, name, shift, s/s, seen by doctor, diagnosis, antibiotic, culture, last shift worked and wing worked on. This will also be filled out by charge nurse per shift. This will assist us in correlating any illnesses shared between our residents and staff, as well as between wings in the facility. Medical records will assist charge nurse in tracking and providing documentation for QA and Infection Control meetings. DON will train staff on policy and procedures by 2/15/17. DON will monitor weekly for 3 months, then monthly for a period of one year. DON also receives daily reports of staff and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245473	A. BUILDING _____ B. WING _____	01/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 13 community acquired or facilty acquired. The columns for culture and resident outcome were blank. There were 14 infections entered for December 2016. The entries in the criteria/site of infection column included: - six urinary tract infections - one cystitis - one leg infection - two pneumonia - one dysuria - one bacteremia - one respiratory infection. There was an antibiotic listed for each entry. The report lacked the signs and symptoms, the date of onset, and the resident room numbers. The report also lacked a determination if the infections were community acquired or facilty acquired. The columns for culture and resident outcome were blank. The collected data lacked any trending or analysis of the infections in the facilty to determine the cause of infection, as well as the room location of resident with infections to determine if they had potential to or were spreading in the facilty. During interview on 1/05/17, at 12:26 p.m. the DON stated that they track employee infections and correlate to resident infections. She stated they complete the Resident Infection spread sheet and discuss at the quality assurance meeting, however, they are currently not completing a tracking and trending summary or analysis of data.	F 441	resident illnesses, as well as listening to shift report so will refer to report on a daily Monday through Friday basis to review and ensure proper documentation. DON will also incorporate resident illnesses into our weekly IDT meetings.	

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F 441	Continued From page 14 During interview on 1/05/2017, at 12:28 p.m. the administrative assistant stated they have nothing really that shows a monthly summary or analysis. She stated they communicate illness of residents verbally and via email but do not have any summary analyses that tracks or trends infection. She further stated that this was one area they were working on.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245473	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/05/2017**

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OAK TERRACE HEALTH CARE CENTER	**640 THIRD STREET** **GAYLORD, MN 55334**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on January 05, 2017. At the time of this survey, Building 01 of Oak Terrace Health Care Center was found to be not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency.	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/30/2017

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

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	245473	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/05/2017**

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K 000	Continued From page 1 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Building 01 of Oak Terrace Health Care Center was constructed in 1974, is one-story in height, has a full basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction. Building 02 of Oak Terrace Health Care Center was constructed in 2008, is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 48 beds and had a census of 42 at time of the survey. Building 1 and Building 2 were surveryed as one building.	K 000		
K 353 SS=C	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.	K 353		2/7/17

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	245473	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/05/2017**

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K 353	Continued From page 2 a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on a review of documentation and an interview with staff, it was determined that the Sprinkler Suppression system is not in accordance with NFPA 101 The Life Safety Code (edition 2012), Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Findings Include: During the facility tour at approximately 8 am, on 01/05/2017, observations revealed 1 sprinkler head in room B-7 is obstructed by rubber bumpers to avoid the closet doors from hitting it. This deficient practice was confirmed by the facility Maintenance staff at the time of discovery and at the exit conference.	K 353	A) Last sprinkler system test performed on 4/1/16 B) Test performed by Security Fire and Sprinkler C) Water supplied by Oak Terrace through City of Gaylord Deficiency - internal piping inspection of sprinkler system shall be performed by Security Fire and Sprinkler on or before 2/7/17 to comply with survey and will be performed every 5 years to remain compliant. Deficiency - Sprinkler head in B7 - bumpers prohibiting closet door from impacting sprinkler head were removed on 1/10/17. The closet door was modified so that the door will not impact the sprinkler head.	

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted
January 20, 2017

Ms. Deborah Barnes, Administrator
Oak Terrace Health Care Center
640 Third Street
Gaylord, MN 55334

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5473027

Dear Ms. Barnes:

The above facility was surveyed on January 3, 2017 through January 5, 2017 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, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00619	A. BUILDING: _____ B. WING _____	01/05/2017

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On January 3-5, 2017 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to to develop an infection control program which included trending and analysis of residents infection control data to reduce the risk of spread of infection to other residents in the facility. This had the potential to affect 42 of 42 residents who resided in the facility. Findings Include: A spreadsheet printout titled, Resident Infection, was provided by the director of nursing (DON).The columns across the spreadsheet were titled: Date ABX [antibiotics] started, Date ABX ended, Date discontinued, Criteria/site of infection,Culture done?,Culture results, ABX used, Resident outcome. The data entered was a monthly listing dated from January 2016 through December 2016. The data was reviewed for October 2016 through December 2016. There were eight infections entered for October 2016. The entries in the criteria/site of infection column included:	21375	Corrected	2/15/17

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21375	Continued From page 3 - one C-diff (clostridium difficile) a bacteria - four urinary tract infections - one cellulitis - one tooth abscess - one respiratory infection There was an antibiotic listed for each entry. The report lacked the signs and symptoms, the date of onset, and the resident room numbers. It also lacked a determination if the infections were community acquired or facilty acquired. The data column for culture and residents outcome were blank. There were 10 infections entered for November 2016. The entries in the criteria/site of infection column included: - two coughs - one pneumonia - one cellulitis - four urinary tract infections. Documented on two of the entries, a question mark was listed as the site of infection. There was an antibiotic listed for each entry. The report lacked the signs and symptoms, the date of onset, and the resident room numbers. It also lacked a determination if the infections were community acquired or facilty acquired. The columns for culture and resident outcome were blank. There were 14 infections entered for December 2016. The entries in the criteria/site of infection column included: - six urinary tract infections - one cystitis	21375		

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21375	Continued From page 4 - one leg infection - two pneumonia - one dysuria - one bacteremia - one respiratory infection. There was an antibiotic listed for each entry. The report lacked the signs and symptoms, the date of onset, and the resident room numbers. The report also lacked a determination if the infections were community acquired or facilty acquired. The columns for culture and resident outcome were blank. The collected data lacked any trending or analysis of the infections in the facilty to determine the cause of infection, as well as the room location of resident with infections to determine if they had potential to or were spreading in the facilty. During interview on 1/05/17, at 12:26 p.m. the DON stated that they track employee infections and correlate to resident infections. She stated they complete the Resident Infection spread sheet and discuss at the quality assurance meeting, however, they are currently not completing a tracking and trending summary or analysis of data. During interview on 1/05/2017, at 12:28 p.m. the administrative assistant stated they have nothing really that shows a monthly summary or analysis. She stated they communicate illness of residents verbally and via email but do not have any summary analyses that tracks or trends infection. She further stated that this was one area they were working on.	21375		

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21375	Continued From page 5 SUGGESTED METHOD OF CORRECTION: The facility could review daily/any newly diagnosed infections and reveiw any other residents that may have signs and symptoms or diagnoses of an infection. The facility could analyze any correlations between resident infections such as close proximety or common caregivers. The facilty could then summarize findings based on investigation and analysis of data. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		2/15/17

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21426	Continued From page 6 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the second step tuberculosis skin testing (TST) was completed for two of five employees (NA-A, H-A) reviewed for infection control. Findings include: Nursing assistant (NA)-A's record indicated a hire date of 11/16/16. NA-A had a TB symptom screen and a first step TST completed on 11/16/16, however, she did not have documentation of a second step TST in her record. Housekeeping assistant (H)-A's record indicated a hire date of 11/8/16. H-A had a TB symptom screen and first step TST completed on 11/8/16, however, she did not have documentation of a second step TST in her record. During interview on 1/14/17, at 2:30 p.m. the director of nursing (DON) stated that they did not have a system in place for tracking that the second step TST was completed. The DON stated this was the responsibility of the employee to come back in the required time frame. The DON also stated that they realize this in a problem and that they are looking at having all new employees go to a local clinic upon hire for a blood test to check for TB as it is difficult to get the second step TST completed in a timely manner. SUGGESTED METHOD OF CORRECTION: The facility could review/develop their system for ensuring timely and appropriate TB second step TST. They could create a schedule that would	21426	Corrected	

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	00619	A. BUILDING: _____ B. WING _____	01/05/2017

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21426	Continued From page 7 alert the responsible person to the due date of the TST. In addition they could complete education with the appropriate employees to ensure implementation. Audits could be conducted and the results brought to the quality committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending	21530		2/15/17

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21530	Continued From page 8 physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality 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 facility failed to ensure the pharmacist recommend the physician taper the dosage or provide justification for continued use of an antidepressant for 1 of 5 residents (R26). Findings include: R26's quarterly Minimum Data Set (MDS) dated 12/17/16, indicated R26 was cognitively intact with a mood screening score of two, indicating minimal depression . The MDS also identified a diagnosis of depression and indicated R26 was taking an antidepressant. R26's physician orders dated 11/17/16, with an original order date of 3/26/12, directed staff to administer Zoloft (antidepressant) 50 milligrams (mg) by mouth (po) daily for a major depressive episode. R26's Medication Regimen Reviews dated 1/26/16, 2/23/16, 3/16/16, 4/19/16, 5/18/16, 6/7/16, 7/19/16, 8/22/16, 9/13/16, 10/25/16, 11/22/16, and 12/19/16, indicated no medication irregularities to be addressed by the facility or	21530	Corrected	

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21530	Continued From page 9 physician. During interview on 1/5/17, at 1:21 p.m. registered nurse (RN)-A stated the pharmacist did not recommend a tapering of the Zoloft or a justification for continued use, as R26 had elevated mood scores indicating depression symptoms. RN-A stated that the pharmacist was planning on reviewing the Zoloft during his visit in January. During telephone interview on 1/5/17, at 1:22 p.m. the consulting pharmacist (CP) stated that he did not recommend, to the physician, a tapering of the Zoloft or justification for continued use, as R26 had elevated mood scores in two quarters over the last year and his assessment was that the dose should continue as ordered. The CP further stated "I certainly don't practice that way, I don't try and bother physicians with that [dose reduction/ justification of continued use], if we can see it." During interview on 1/5/17, at 1:30 p.m. the director of nursing (DON) stated tapering and justification of use should be done according to the requirements. The facility policy Psychotropic Medications- Use Of dated 1/12, indicated "Residents receiving psychotropic medications will have a gradual dose reduction attempted unless clinically contraindicated with appropriate documentation by the MD." SUGGESTED METHOD OF CORRECTION: The administrator, DON and CP, could review and revise policies and procedures for proper monitoring of medication usage. Staff could be	21530		

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21530	Continued From page 10 educated as necessary. The DON or designee could monitor medications on a regular basis to ensure compliance with state and federal regulations. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21530		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the physician	21540	Corrected	2/15/17

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21540	Continued From page 11 tapered the dosage or provided justification for continued use of an antidepressant for 1 of 5 residents (R26). In addition, the facility failed to ensure side effect and efficacy monitoring was provided for antidepressant use for 1 of 5 residents (R31) reviewed for unnecessary medications. Findings include: R26's quarterly Minimum Data Set (MDS) dated 12/17/16, indicated R26 was cognitively intact with a mood screening score of two, indicating minimal depression. The MDS also identified a diagnosis of depression and indicated that R26 was taking an antidepressant. R26's physician orders dated 11/17/16, with an original order date of 3/26/12, directed staff to administer Zoloft (antidepressant) 50 milligrams (mg) by mouth (po) daily for a major depressive episode. R26's care plan dated 7/4/16, indicated R26 was taking Zoloft 50 mg daily. The care plan indicated a monthly review by the pharmacist was completed, however, did not address tapering or justification of continued use. R26's medical record did not indicate a dose reduction for the Zoloft was attempted or a justification of use was given by R26's physician for continued use. During interview on 1/4/16, at 2:21 p.m. nursing assistant (NA)-B stated that R26 regularly participated in activities and never was depressed. During interview on 1/5/16, at 8:55 a.m. R26	21540		

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21540	Continued From page 12 stated although she wanted to go home she was not sad and was happy. She also stated she had never been depressed. During interview on 1/5/17, at 1:21 p.m. registered nurse (RN)-A stated R26 had not had a taper since 3/26/12 or justification of continued use for Zoloft from the physician. During interview on 1/5/17, at 1:30 p.m. the director of nursing (DON) stated tapering and justification of use should be done according to the requirements. R31's quarterly MDS dated 11/8/16, indicated R31 had severe cognitive impairment with a staff mood screening score of zero, indicating no depression. The MDS also identified diagnoses of an anxiety disorder and psychosis and was taking an antidepressant. R31's physician orders dated 1/3/17, with an original order date of 5/26/16, directed staff to administer trazodone (antidepressant used for sleep) 100 mg via g-tube at bedtime for psychophysiologic insomnia. R31's care plan dated 5/21/15, directed staff to administer trazodone every night for sleeplessness and to monitor for any adverse side effects. The care plan did not direct staff to monitor for hours of sleep. R31's medical record did not indicate sleep monitoring was done periodically or if R31 was having any side effects of the trazodone. During observation on 1/4/17, at 2:06 p.m. R31 was observed to be sleeping in her wheelchair in the common area near the nursing desk.	21540		

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21540	Continued From page 13 During interview on 1/5/17, at 9:17 a.m. licensed practical nurse (LPN)-A stated they did not regularly document that R31 did not have any side effects or monitor for hours of sleep. During interview on 1/5/17, at 12:11 p.m. the DON stated the process for tracking potential side effects was by a task in the electronic record or in the quarterly charting. The DON further stated R31 did not have a task set up for the nurses to monitor for side effect or document there were no side effects noted in the quarterly charting. The DON stated the current system for sleep monitoring was verbally from shift to shift and there was no indication in R31's medical record that R31's sleep had been monitored. The facility policy Psychotropic Medications- Use Of dated 1/12, indicated "Side effects will be observed on a daily basis with medication administration with documentation of side effect monitoring at a minimum-monthly. Residents receiving psychotropic medications will have a gradual dose reduction attempted unless clinically contraindicated with appropriate documentation by the MD." The facility policy Sleep Monitoring dated 7/5/12, indicated "Residents will be rounded on hourly during the night shift by the nursing staff to ensure that residents receives a restful nights sleep. Report to the physician any resident having difficulties on a regular basis sleeping." The policy did not address how the facility would monitor sleep periodically for residents taking medications to assist with sleep. SUGGESTED METHOD FOR CORRECTION:	21540		

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21540	Continued From page 14 The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures to ensure proper monitoring of medication usage. Nursing staff could be educated as necessary to the importance of the medication monitoring. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIME FRAME FOR CORRECTION: Twenty-one (21) days.	21540		