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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: B0CI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00124

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245536**

2.STATE VENDOR OR MEDICAID NO.
(L2) **824025600**

3. NAME AND ADDRESS OF FACILITY
(L3) **GREEN LEA MANOR**
(L4) **115 NORTH LYNDALE, RR 2 BOX 49**
(L5) **MABEL, MN** (L6) **55954**

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 **03/24/2012** (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 IMR**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **51** (L18)

13.Total Certified Beds **51** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	51			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 03/28/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 05/15/2012 (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
06/13/1989
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/13/2012
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

A Post Certification Revisit (PCR) was completed by the Departments of Health and Public Safety to verify correction of deficiencies issued pursuant to the February 9, 2012. Based on the PCR, it has been determined that the facility has achieved substantial compliance pursuant to the February 9, 2012 standard survey, effective March 6, 2012. Refer to the CMS 2567b for both health and life safety code.

Effective March 6, 2012, the facility is certified for 51 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5536

May 15, 2012

Ms. Julie Vettleson, Administrator
Green Lea Manor
115 North Lyndale, Rr 2 Box 49
Mabel, Minnesota 55954

Dear Ms. Vettleson:

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 6, 2012 the above facility is certified for:

51 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 51 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,

Mark Meath

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4118 Fax #: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 28, 2012

Ms. Julie Vettleson, Administrator
Green Lea Manor
115 North Lyndale, Rural Route 2 Box 49
Mabel, Minnesota 55954

RE: Project Number S5536021

Dear Ms. Vettleson:

On February 16, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 9, 2012. This survey found the most serious deficiencies to bewidespread 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 24, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 29, 2012 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 9, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 6, 2012. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 9, 2012, effective March 6, 2012 and therefore remedies outlined in our letter to you dated February 16, 2012, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Gary Nederhoff, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (507) 206-2731 Fax: (507) 206-2711

Enclosure

cc: Licensing and Certification File 5536r12.rtf

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

Form Approved
OMB NO. 0938-0390

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245536	A. Building B. Wing	3/24/2012

Name of Facility	Street Address, City, State, Zip Code
GREEN LEA MANOR	115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954

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 F0156 Reg. # 483.10(b)(5) - (10), 483.10(t LSC	Correction Completed 03/06/2012	ID Prefix F0371 Reg. # 483.35(i) LSC	Correction Completed 03/06/2012	ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	Correction Completed 03/06/2012
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 MM/GPN	Date: 03/28/2012	Signature of Surveyor: 10160	Date: 03/24/2012
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 2/9/2012		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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245536	01 - MAIN BUILDING 01	2/29/2012

Name of Facility	Street Address, City, State, Zip Code
GREEN LEA MANOR	115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0025	02/29/2012	ID Prefix Reg. # NFPA 101 LSC K0064	02/27/2012	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By MM/PS	Date: 03/28/2012	Signature of Surveyor: 25822	Date: 02/29/2012
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 2/7/2012		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: B0CI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00124

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245536**

2.STATE VENDOR OR MEDICAID NO.
(L2) **824025600**

3. NAME AND ADDRESS OF FACILITY
(L3) **GREEN LEA MANOR**
(L4) **115 NORTH LYNDALE, RR 2 BOX 49**
(L5) **MABEL, MN** (L6) **55954**

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 **02/09/2012** (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 IMR**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **51** (L18)

13.Total Certified Beds **51** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	51			
(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):
At the time of the February 9, 2012 standard survey the facility was not in substantial compliance with Federal participation requirements. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE Date :
Marietta Lee, HFE NEII 03/02/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 03/08/2012 (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
06/13/1989
(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
Uploaded 03/13/12 DB B0CI

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 5981

February 16, 2012

Ms. Julie Vettleson, Administrator
Green Lea Manor
115 North Lyndale, Rural Route 2 Box 49
Mabel, Minnesota 55954

RE: Project Number S5536021

Dear Ms. Vettleson:

On February 9, 2012, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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:

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904

Telephone: (507) 206-2731

Fax: (507) 206-2711

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 20, 2012, 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 March 20, 2012 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 9, 2012 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 9, 2012 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: 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
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Gary Nederhoff, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (507) 206-2731 Fax: (507) 206-2711

Enclosure

cc: Licensing and Certification File 5536s12.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245536	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an 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	Please see attached forms with POC.	All tags 03-06-12 sph
F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 156 3-2-12 sph		

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

Executive Director 2/29/12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245536	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954

(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 156	Continued From page 1 inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245536	A. BUILDING _____ B. WING _____	02/09/2012

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F 156	Continued From page 2 misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide 3 of 3 residents (R60, R21, and R62) in the sample with the appropriate Medicare non-coverage notices. Findings include:	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245536	A. BUILDING _____ B. WING _____	02/09/2012

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GREEN LEA MANOR	115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954

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F 156	Continued From page 3 R60, R21, R62 did not receive "Notice of Medicare Provider Non-coverage" notice which informed residents of the right to an expedited review by the Quality Improvement Organization when Medicare services were terminated. R60 was admitted to the facility 10/16/11. R60 was notified services were no longer covered by Medicare beginning 12/10/11. R60 did not receive Notice of Medicare Provider Non-Coverage which included the right to expedited review by the quality review organization. R21 was admitted to the facility 12/3/09. R21 was notified services were no longer covered by Medicare beginning 9/3/11. R21 did not receive Notice of Medicare Provider Non-Coverage which included the right to expedited review by the quality review organization. R62 was admitted to the facility 11/15/11. R62 was notified services were no longer covered by Medicare beginning 12/16/11. R62 did not receive Notice of Medicare Provider Non-Coverage which included the right to expedited review by the quality review organization. During interview on 2/9/12, at 1:15 a.m., the director of nursing verified R60, R21, and R62, had received services covered under Medicare part A, the services terminated, and they had not exhausted their Medicare days. During interview at that time, the director of nursing stated the facility corporation instructed they no longer needed to inform residents of the right to an expedited review.	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245536	A. BUILDING _____ B. WING _____	02/09/2012

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F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy review, the facility failed to distribute food in a sanitary manner for residents in the main dining room and this had the potential to affect 46 out of 47 residents in the facility. Findings include: The certified dietary manager (CDM) and the dietary aide (DA)-A would contaminate their disposable gloves then would touch food being served to the residents during the meal service. On 2/7/12, at 7:44 a.m., CDM was observed preparing the breakfast trays in the main dining room. CDM was wearing disposable gloves and was observed to touch several resident trays, open sugar packets, picked up toast to apply jelly, put peanut butter in a cup, picked up coffee cup and touched the coffee machine. The CDM had not changed gloves when. On 2/9/12 at 7:34 a.m., CDM was observed preparing the breakfast trays in the main dining room. CDM pulled tray forward on counter cut up	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245536	A. BUILDING _____ B. WING _____	02/09/2012

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F 371	Continued From page 5 waffle with pizza cutter, grabbed next tray opened sugar packets, poured milk on the cereal, picked up toast with gloved hand and jellied the toast, pushed tray aside and pulled next tray forward, moved chair in the dining room, picked up tray and took tray to resident and removed the plate, juice glasses from tray. At 7:45 a.m., the CDM changed gloves, washed hands and applied new gloves, opened jelly packet, grabbed coffee cup and filled with coffee, pulled tray forward, picked up small cup and filled with peanut butter, pushed tray to the side, pulled down the sides of her shirt, grabbed next tray opened sugar packets put on cereal, grabbed milk container and poured on cereal, proceeded to cut up waffle with right hand and touched waffle with left hand On 2/9/12 at 7:41 a.m., DA-A was observed preparing the breakfast trays in the main dining room. DA-A put gloves on, placed waffles in the toaster, picked up resident breakfast tray from steam table and placed on counter, grabbed glass, pushed prune juice button on juice machine, put glass on tray, grabbed waffles out of toaster put in steam table. At 7:44 a.m., changed gloves and washed hands. At 7:51 a.m., gloves were put on, put waffles in toaster, pushed cart with milk and with soiled gloves grabbed waffles out of toaster and placed in steam table, grabbed waffles out of toaster and put in steam table, grabbed tray out of cart brought to steam table, put waffles from the toaster to the steam table, pushed tray on counter, with right hand pulled out 3 pieces of bread and 1 waffle and put in toaster, set up resident tray used tongs to take toast out of steam table onto resident plate, picked up tray put on counter, grabbed glass of milk put on tray, pushed tray across counter, grabbed toast out of	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245536	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 6	F 371		

toaster, buttered with knife holding toast with gloved hand, grabbed waffle out of toaster, put waffle and toast in steam table, grabbed new tray placed on counter, filled up toaster with 3 waffles and 3 pieces of toast, threw away bread wrapper, grabbed waffles from toaster and put in steam table, picked up toast with tongs and set up tray, picked up cream and glass of juice, pushed tray across counter, took 3 pieces of toast butter with knife holding toast with left gloved hand cut toast in half, removed waffle out of toaster and placed in steam table. Changed gloves and washed hands at 8:00 a.m.

On 2/9/12 at 8:06 a.m., CDM was interviewed and acknowledged that when putting jelly on the toast she did pick up the toast with gloved. On further interview the CDM would expect dietary staff to remove gloves after they make the toast and waffles. The staff had completed the safe-serve training but identified that it had been a while ago and there had not been any formal training since. The goal was to get the warm toast out to the residents as soon as possible. The CDM indicated staff has some training on the computer called preventing food borne illness in the kitchen. CDM indicated that there would be more training done with staff.

Policies were requested from the CDM concerning washing of hands and glove use to promote a safe food handling practices and none were provided. On 2/9/12 at 9:21 a.m., information was provided by the Administrator regarding the training that had 100% completion on the computer regarding preventing food borne illness in the kitchen. One of the objectives from the training was to describe how hand washing

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F 371	Continued From page 7 helps prevent foodborne illnesses in residents.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 431	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that only authorized personnel had access to 1 of 2 medication rooms in the facility. Findings include: Non-licensed staff had access to the medication room allowing access to medications being stored in an unlocked refrigerator. An observation was made on 2/9/12 at 9:15 a.m., which revealed the North medication room door was kept open. Licensed practical nurse (LPN)-A was standing outside of the medication room and asked medical records (MR)-A personnel if she was going to stay in the area. MR-A indicated that she was going to stay. LPN-A left the area and went into another office not in view of the medication room leaving the door to the medication room braced open and MR-A standing in front of the medication room. On 2/9/12 at 9:16 a.m., MR-A was interviewed and verified that she was not a licensed nurse. On 2/9/12 at 9:21 a.m., Administrator was interviewed and verified that no one was to have access to the medication room except the nurses. Maybe staff felt that if someone was standing by the medication room the door could be kept opened. This is something we have been working on constantly. On 2/9/12 at 9:26 a.m., the director of nursing was interviewed and verified that leaving the medication door open without licensed staff present was a violation of the facility policy. We	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 431	Continued From page 9 have put a special lock on the door that self-locks. On 2/9/12 at 11:20 a.m., interview with LPN-A indicated that only nurses have access to the medication room and did indicate that if the nurses ' station was full the medical records person does go into the medication room and uses the counter in the medication room to complete their work. LPN-A verified the medical records person was not a nurse. A review of the facility ' s policy dated 5/26/11 on Medication Storage indicated the medication rooms must be locked unless within direct visual observation of the nurse or trained medication aide.	F 431		

Green Lea Manor

February 29, 2012

Plan of Correction

F 156B NOTICE OF RIGHTS RULES, SERVICES, CHARGES

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission for an agreement by the facility of the truth of the facts alleged on the conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to

F156B:

1. The facility is providing residents with the appropriate Medicare non-coverage notice which informs residents of the right to an expedited review by the Quality Improvement Organization when Medicare services are terminated.
2. The facility will provide the appropriate Medicare non-coverage notice according to facility policy.
3. Inservices were presented by the DNS on February 27 and 29 educating all appropriate licensed nurses on the Medicare denial process and the required forms for residents who receive medicare benefits.
4. The DNS or designee will audit two times per week for four weeks and then weekly until substancial compliance to ensure that the policies and procedures for Medicare non-coverage notice are followed. The data collected will be reviewed/discussed at the monthly Quality Improvement meetings for further evaluation, interventions and ongoing audits.

Completion date: 03/06/2012

F371F FOOD SANITATION-STORE/PREPARE/SERVE

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission for an agreement by the facility of the truth of the facts alleged on the conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to

F371F:

1. The facility is storing, preparing, and serving food in a sanitary manner.
2. The facility will serve food according to facility policy. The policies and procedures related to sanitary meal service were reviewed by the dietician and found to be appropriate.
3. On March 1 and March 6 2012 the dietician/dietary manager will inservice the dietary staff on serving food in a sanitary manner. The dietary staff will be educated on food service techniques, including appropriate handwashing and glove use, to minimize the risk of food borne infections.
4. The dietary manager or designee will audit compliance by random observations of infection control techniques of the food service personnel two times a week for four weeks and then weekly until substancial compliance. The data collected will be reviewed/discussed at the monthly Quality Improvement meetings for further evaluation, interventions and ongoing audits.

Completion date: 03/06/2012

F431 MEDICATION STORAGE

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission for an agreement by the facility of the truth of the facts alleged on the conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to

F431:

1. Only licensed nurses and trained medication aids (TMAs) have access to the medication storage rooms. No unauthorized personnel are to be in the medication storage areas unless accompanied by a nurse or a TMA. Only authorized personnel have access to the keys.
2. It is a facility policy that the medication storage areas be locked unless within direct visual observation of a licensed nurse/TMA. It is a facility policy that all medication is under lock and key when the nurse/TMA does not have the medication within direct visual observation.

3. Inservices were presented on February 27 and 29, 2012 re-educating all licensed nurses and and TMAs on the proper storage of medication to minimize the risk of access to unauthorized persons.
4. The DNS/designee will audit two times per week for four weeks and then weekly until substancial compliance to ensure that the policies and procedures for medication storage are followed. The data collected will be reviewed/discussed at the monthly Quality Improvement meetings for further evaluation, interventions and ongoing audits.

Completion Date: 03/06/2012

4658.0815 LICENSING ORDER FOR MANTOUX TESTING

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission for an agreement by the facility of the truth of the facts alleged on the conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to

4658.0815:

1. All new employees will have a two-step tuberculin skin test (TST) or provide records of annual screening. Records of the TB blood test or a chest x-ray may be provided instead of the TST.

2. The facility Tuberculosis Infection Control Plan was reviewed by the Director of Nursing and is appropriate and in accordance with state and federal guidelines.

3. Inservices were presented on February 27 and 29, 2012 re-educating all licensed nurses on the Tuberculosis Infection Control Plan, including the requirements for a 2-step tuberculin skin test, chest x-ray or blood test.

4. The DNS/designee will audit once per week for four weeks and then weekly until substancial compliance to ensure that the policies and procedures for tuberculosis infection control are followed. The data collected will be reviewed/discussed at the monthly Quality Improvement meetings for further evaluation, interventions and ongoing audits.

Completion date: 03/06/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245536	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Division. At the time of this survey, Green Lea Manor was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Patrick Sheehan, Supervisor Health Care Fire Inspections	K 000	POC ok PS 2-28-12 RECEIVED FEB 28 2012 MINNESOTA DEPT OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

3.21.12 DC..
EXIT: 02.09.2012

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

Julie Sellers, Executive Director — 2/27/12

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

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K 000	Continued From page 1	K 000		

State Fire Marshal Division
444 Cedar St., Suite 145
St. Paul, MN 55101- 5145
Pat.Sheehan@state.mn.us
Fax: 651-215-0525

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Green Lea Manor is a 1-story building with partial basement. The building was constructed at 3 different times. The original building was constructed in 1961 and was determined to be of Type II(222) construction. In 1969, addition was constructed and was determined to be of Type II(222) construction. In 1989, another two additions were constructed and was determined to be of Type II (111) construction. Because the original building and the 2 additions meet the construction type allowed for existing buildings, the facility was surveyed as one building Type II (111) .

The building is fully sprinklered and has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245536	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 notification. The facility has a capacity of 51 beds and had a census of 47 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier wall in accordance with the following requirements of 2000 NFPA 101, Section 19.3.7.3, and 8.3.4.1. The deficient practice could affect all 47 residents. Findings include: On facility tour between 8:39 AM and 11:30 AM on 02/07/2012, observation revealed that the	K 025		

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K 025	Continued From page 3 smoke barrier wall by room 204 has a open penetration (12 inch x 12 inch) above the hard deck ceiling. This deficient practice was confirmed by the Maintenance Director (JD) at the time of discovery.	K 025	K25 Smoke barrier by 204's with open penetration 12"X12" hole will be closed by 02/29/12.	2-29-12
K 064 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by: Based on documentation review and staff interview, it was determined that the facility failed to maintain portable fire extinguishers in accordance with NFPA 101-2000 edition, Section 9.7.4.1 and NFPA 10. The deficient practice could affect all 47 residents. Findings include: On facility tour between 8:39 AM and 11:30 AM on 02/07/2012, the review of the fire extinguisher annual inspection documentation for the past 12 months revealed, that the facility failed to conduct the annual fire extinguisher inspection with-in 12 months. Clarey's Fire Safety annual inspection report dates were 10/19/2010 and	K 064	K64 Maintenance supervisor will Monitor so fire exthinguisher inspections are performed within 12 month timeframe..	2-27-12

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K 064	Continued From page 4 01/04/2012 This deficient practice was confirmed by the Maintenance Director (JD) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 064		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 5981

February 16, 2012

Ms. Julie Vettleson, Administrator
Green Lea Manor
115 North Lyndale, Rural Route 2 Box 49
Mabel, Minnesota 55954

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5536021

Dear Ms. Vettleson:

The above facility was surveyed on February 7, 2012 through February 9, 2012 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 18 Wood Lake Drive Southeast Rochester, Minnesota 55904. 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,

Gary Nederhoff, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (507) 206-2731 Fax: (507) 206-2711

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

5536s12lic.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MAR 1 2012 Minn Dept of Health Rochester Office 00124	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954

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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: On February 7, 8 and 9, 2012 surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	3-2-12 vsm 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.	

Minnesota Department of Health

Executive Director 2/28/12

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

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2 000	Continued From page 1 Certification Program; 18 Wood Lake Drive SE, Rochester, MN 55904.	2 000	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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
21000	MN Rule 4658.0610 Subp. 4 Dietary Staff Requirements-Hygiene. Subp. 4. Hygiene. Dietary staff must thoroughly wash their hands and the exposed portions of their arms with soap and warm water in a hand washing facility before starting work, during work as often as is necessary to keep them clean, and after smoking, eating, drinking, using the toilet, or handling soiled equipment or utensils. Dietary staff must keep their fingernails clean and trimmed. This MN Requirement is not met as evidenced	21000		

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21000	Continued From page 2 by: Based on observation, interview and policy review, the facility failed to distribute food in a sanitary manner for residents in the main dining room and this had the potential to affect 46 out of 47 residents in the facility. Findings include: The certified dietary manager (CDM) and the dietary aide (DA)-A would contaminate their disposable gloves then would touch food being served to the residents during the meal service. On 2/7/12, at 7:44 a.m., CDM was observed preparing the breakfast trays in the main dining room. CDM was wearing disposable gloves and was observed to touch several resident trays, open sugar packets, picked up toast to apply jelly, put peanut butter in a cup, picked up coffee cup and touched the coffee machine. The CDM had not changed gloves when. On 2/9/12 at 7:34 a.m., CDM was observed preparing the breakfast trays in the main dining room. CDM pulled tray forward on counter cut up waffle with pizza cutter, grabbed next tray opened sugar packets, poured milk on the cereal, picked up toast with gloved hand and jellied the toast, pushed tray aside and pulled next tray forward, moved chair in the dining room, picked up tray and took tray to resident and removed the plate, juice glasses from tray. At 7:45 a.m., the CDM changed gloves, washed hands and applied new gloves, opened jelly packet, grabbed coffee cup and filled with coffee, pulled tray forward, picked up small cup and filled with peanut butter, pushed tray to the side, pulled down the sides of her shirt, grabbed next tray opened sugar packets put on cereal, grabbed milk container and poured on cereal, proceeded to cut up waffle with right hand and touched waffle with left hand	21000		

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21000	Continued From page 3 On 2/9/12 at 7:41 a.m., DA-A was observed preparing the breakfast trays in the main dining room. DA-A put gloves on, placed waffles in the toaster, picked up resident breakfast tray from steam table and placed on counter, grabbed glass, pushed prune juice button on juice machine, put glass on tray, grabbed waffles out of toaster put in steam table. At 7:44 a.m., changed gloves and washed hands. At 7:51 a.m., gloves were put on, put waffles in toaster, pushed cart with milk and with soiled gloves grabbed waffles out of toaster and placed in steam table, grabbed waffles out of toaster and put in steam table, grabbed tray out of cart brought to steam table, put waffles from the toaster to the steam table, pushed tray on counter, with right hand pulled out 3 pieces of bread and 1 waffle and put in toaster, set up resident tray used tongs to take toast out of steam table onto resident plate, picked up tray put on counter, grabbed glass of milk put on tray, pushed tray across counter, grabbed toast out of toaster, buttered with knife holding toast with gloved hand, grabbed waffle out of toaster, put waffle and toast in steam table, grabbed new tray placed on counter, filled up toaster with 3 waffles and 3 pieces of toast, threw away bread wrapper, grabbed waffles from toaster and put in steam table, picked up toast with tongs and set up tray, picked up cream and glass of juice, pushed tray across counter, took 3 pieces of toast butter with knife holding toast with left gloved hand cut toast in half, removed waffle out of toaster and placed in steam table. Changed gloves and washed hands at 8:00 a.m. On 2/9/12 at 8:06 a.m., CDM was interviewed and acknowledged that when putting jelly on the toast she did pick up the toast with gloved. On further interview the CDM would expect dietary	21000		

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21000	Continued From page 4 staff to remove gloves after they make the toast and waffles. The staff had completed the safe-serve training but identified that it had been a while ago and there had not been any formal training since. The goal was to get the warm toast out to the residents as soon as possible. The CDM indicated staff has some training on the computer called preventing food borne illness in the kitchen. CDM indicated that there would be more training done with staff. Policies were requested from the CDM concerning washing of hands and glove use to promote a safe food handling practices and none were provided. On 2/9/12 at 9:21 a.m., information was provided by the Administrator regarding the training that had 100% completion on the computer regarding preventing food borne illness in the kitchen. One of the objectives from the training was to describe how hand washing helps prevent foodborne illnesses in residents. SUGGESTED METHOD OF CORRECTION: The Director of Dietary Services could develop a policy and procedure to ensure that food was served in a sanitary manner. Staff could receive training regarding handwashing and glove use to ensure knowledge of safe food handling while serving residents. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21000		
21415	MN Rule 4658.0815 Subp. 2 Employee Tuberculosis Program Subp. 2. Pursuant to Minnesota Rule 4658 0040 and as defined in Minnesota Department of Health Informational Bulletin 09-02, Minnesota Rule 4658.0815 Subpart 2 Employee	21415		

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21415	Continued From page 5 Tuberculosis Program is waived. Conditions of Waiver: - All paid and unpaid HCWs (as defined in the "CDC Guidelines") must receive baseline TB screening. This screening must include a written assessment of any current TB symptoms, and a two-step tuberculin skin test (TST) or single interferon gamma release assay (IGRA) for M. tuberculosis (e.g., QuantiFERON® TB Gold or TB Gold - In Tube, T-SPOT ® .TB). - All paid and unpaid HCWs (as defined in the "CDC Guidelines") must receive serial TB screening based on the facility 's risk level: (1) low risk - not needed; (2) medium risk - yearly; (3) potential ongoing transmission - consult the Minnesota Department of Health's TB Prevention and Control Program at 651-201-5414. · HCWs with abnormal TB screening results must receive follow-up medical evaluation according to current CDC recommendations for the diagnosis of TB. See www.cdc.gov/tb · All reports or copies of HCW TSTs, IGRAs for M. tuberculosis, medical evaluation, and chest radiograph results must be maintained in the HCW 's employee file. · All HCWs exhibiting signs or symptoms consistent with TB must be evaluated by a physician within 72 hours. These HCWs must not return to work until determined to be non-infectious.	21415		

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21415	Continued From page 6 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure new employees received the 2-step tuberculin skin test for 2 of 3 new employees (E1 and E2) reviewed. Findings include: E1 was hired 12/20/11 and received the first step of the TST on 1/2/12. A second step of the TST was not administered. E2 was hired 11/7/11 and received the first step of the TST on 11/7/11. A second step of the TST was not administered. The facility policy entitled Tuberculosis Infection Control Plan (TBICP) Policy and Procedure was reviewed. The TBICP procedure indicated that healthcare workers were to have a pre-placement TST and if unable to provide an annual screening from elsewhere, were to receive the second step TST. During an interview on 2/8/12, at 1:30 p.m. the director of nursing indicated she was responsible for monitoring and ensuring new employees received the 2-step tuberculin skin test and verified these 2 employees had not received the second step.	21415		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home	21610		

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21610	Continued From page 7 must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that only authorized personnel had access to 1 of 2 medication rooms in the facility. Findings include: Non-licensed staff had access to the medication room allowing access to medications being stored in an unlocked refrigerator. An observation was made on 2/9/12 at 9:15 a.m., which revealed the North medication room door was kept open. Licensed practical nurse (LPN)-A was standing outside of the medication room and asked medical records (MR)-A personnel if she was going to stay in the area. MR-A indicated that she was going to stay. LPN-A left the area and went into another office not in view of the medication room leaving the door to the medication room braced open and MR-A standing in front of the medication room. On 2/9/12 at 9:16 a.m., MR-A was interviewed and verified that she was not a licensed nurse. On 2/9/12 at 9:21 a.m., Administrator was interviewed and verified that no one was to have access to the medication room except the nurses. Maybe staff felt that if someone was standing by the medication room the door could be kept opened. This is something we have been working on constantly. On 2/9/12 at 9:26 a.m., the director of nursing	21610		

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21610	Continued From page 8 was interviewed and verified that leaving the medication door open without licensed staff present was a violation of the facility policy. We have put a special lock on the door that self-locks. On 2/9/12 at 11:20 a.m., interview with LPN-A indicated that only nurses have access to the medication room and did indicate that if the nurses ' station was full the medical records person does go into the medication room and uses the counter in the medication room to complete their work. LPN-A verified the medical records person was not a nurse. A review of the facility ' s policy dated 5/26/11 on Medication Storage indicated the medication rooms must be locked unless within direct visual observation of the nurse or trained medication aide. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing and/or designee could review appropriate policies and procedures to provide only authorized access to storage of medications. Staff education of policy implementation. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21610		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying	21800		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEA MANOR	115 NORTH LYNDALE, RR 2 BOX 49 MABEL, MN 55954

(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) COMPLETE DATE
21800	Continued From page 9 written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide 3 of 3 residents (R60, R21, and R62) in the sample with the appropriate Medicare non-coverage notices. Findings include: R60, R21, R62 did not receive "Notice of Medicare Provider Non-coverage" notice which informed residents of the right to an expedited review by the Quality Improvement Organization when Medicare services were terminated.	21800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00124	A. BUILDING _____ B. WING _____	02/09/2012

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21800	Continued From page 10 R60 was admitted to the facility 10/16/11. R60 was notified services were no longer covered by Medicare beginning 12/10/11. R60 did not receive Notice of Medicare Provider Non-Coverage which included the right to expedited review by the quality review organization. R21 was admitted to the facility 12/3/09. R21 was notified services were no longer covered by Medicare beginning 9/3/11. R21 did not receive Notice of Medicare Provider Non-Coverage which included the right to expedited review by the quality review organization. R62 was admitted to the facility 11/15/11. R62 was notified services were no longer covered by Medicare beginning 12/16/11. R62 did not receive Notice of Medicare Provider Non-Coverage which included the right to expedited review by the quality review organization. During interview on 2/9/12, at 1:15 a.m., the director of nursing verified R60, R21, and R62, had received services covered under Medicare part A, the services terminated, and they had not exhausted their Medicare days. During interview at that time, the director of nursing stated the facility corporation instructed they no longer needed to inform residents of the right to an expedited review. SUGGESTED METHOD OF CORRECTION: The director of social services or designee could educate all appropriate staff members on the process of the required forms for residents who receive medicare benefits. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance and	21800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21800	Continued From page 11 report the findings to the Quality Assurance Committee TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21800		