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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: BXXH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00576

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245548**

2.STATE VENDOR OR MEDICAID NO.
(L2) **230743000**

3. NAME AND ADDRESS OF FACILITY
(L3) **TUFF MEMORIAL HOME**
(L4) **505 EAST 4TH STREET**
(L5) **HILLS, MN** (L6) **56138**

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 **07/18/2013** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (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	IID
	50			
(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 :
Maria King, Assistant Program Manager 07/25/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 12/20/2013 (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
03/01/1991
(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 12/31/2013 CO. BXXH12

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/31/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN# 24-5548

At the time of the standard survey completed June 5, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required. The facility was given an opportunity to correct before remedies were imposed.

On July 18, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by the review of the plan of correction and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on June 5, 2013 effective July 5, 2013, therefore the remedies outlined in our letter to you dated June 20, 2013, will not be imposed.
See the attached CMS-2567B form for the results of the July 18, 2013 revisit.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5548 December 20, 2013

Mr. Dana Dahlquist, Administrator
Tuff Memorial Home
505 East 4th Street
Hills, Minnesota 56138

Dear Mr. Dahlquist:

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 July 5, 2013 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 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,

Shellae Dietrich

Shellae Dietrich, 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) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

July 25, 2013

Mr. Dana Dahlquist, Administrator
Tuff Memorial Home
505 East 4th Street
Hills, Minnesota 56138

RE: Project Number S5548022

Dear Mr. Dahlquist:

On June 20, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 5, 2013. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On July 18, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 5, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 5, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 5, 2013, effective July 5, 2013 and therefore remedies outlined in our letter to you dated June 20, 2013, 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,

Colleen Leach

Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring

Enclosure
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245548	A. Building B. Wing	7/18/2013

Name of Facility	Street Address, City, State, Zip Code
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

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 **F0242** Reg. # **483.15(b)** LSC	Correction Completed **07/05/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **07/05/2013**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **07/05/2013**
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **07/05/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **07/05/2013**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **07/05/2013**
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	Date:	Signature of Surveyor:	Date:
	MK/cbl	07/25/2013	08769	07/18/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 6/5/2013

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: BXXH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00576

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245548**
2.STATE VENDOR OR MEDICAID NO.
(L2) **230743000**

3. NAME AND ADDRESS OF FACILITY
(L3) **TUFF MEMORIAL HOME**
(L4) **505 EAST 4TH STREET**
(L5) **HILLS, MN** (L6) **56138**

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 **06/05/2013** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (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: B (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(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 Standard survey, the facility was not in substantial compliance with Federal certification regulations. Please refer to the CMS 2567 for health along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE — Date :
Connie Brady, HFE NEII — 07/02/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Colleen B. Leach, Program Specialist — 07/25/2013 (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
03/01/1991
(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 7/31/2013 ML

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 # 7011 2000 0002 5143 3304

June 20, 2013

Mr. Dana Dahlquist, Administrator
Tuff Memorial Home
505 East 4th Street
Hills, Minnesota 56138

RE: Project Number S5548022

Dear Mr. Dahlquist:

On June 11, 2013, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), 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;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

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 July 15, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

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

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 September 5, 2013 (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 December 5, 2013 (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:

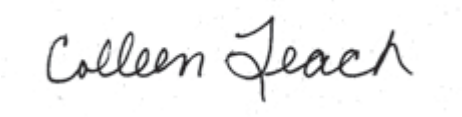
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____ JUL 1 - 2013 MN Dept of Health Rochester	06/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(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		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide each resident the opportunity to make choices regarding their daily routines for 2 of 3 residents (R18 and R25) in the sample. Findings include: R18 had his morning routine changed without the opportunity to be involved in the decision to make that choice. It was observed on 6/3/13 at 5:22 p.m. that R18 had limited range of motion to his left arm and	F 242 7/2/13 JPN	SEE Attached	7/5/13 JPN

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

Dana Wahlquist | Administrator | 6-25-2013

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
	245548	A. BUILDING _____ B. WING _____ JUL 1 - 2013 MN Dept of Health Rochester	06/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(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 242	Continued From page 1	F 242		

hand and left leg and foot due hemiplegia of left side. According to the care plan, R18 required the assist of one (1) staff with dressing, transferring and personal hygiene/grooming. During interview with R18 on 6/3/13 at 5:22 p.m. it was learned that instead of getting out of bed at 5:30 a.m. each morning, R18 ' s schedule had been changed to 6:30 a.m. R18 said, "They switched the time and did not ok it with me" and "I prefer they keep the same schedule." On 6/4/13 at 9:30 a.m. R18 stated that he had talked with the administrator at breakfast "this morning" (on 6/4/13) and informed him of his dismay about the nursing assistant not being able to come and get him up between 5:00 a.m. and 5:30 a.m. R18 indicated the administrator stated, "I'm sorry" but did not offer any alternative and/or initiate a discussion of mutual resolution.

An interview was conducted with certified nursing assistant (CNA)-A on 6/4/13 at 10:35 a.m. who use to come at 5:00 a.m. to get R18 up early. CNA-A indicated that after a meeting between the administrator, herself and the director of nurses (DON), CNA-A was mandated not to come to work at 5:00 a.m. even though R18 preferred to be gotten up at 5:00 a.m. CNA-A stated she felt badly for R18 and told him she was "sorry." CNA-A verbalized that she had been willing to accommodate R18's schedule and "do what was best", even if it meant that she came earlier to work. She confirmed the discussion to alter the morning schedule had not included R18 in the decision.

Further clarification with R18 on 6/4/13 at 10:55 a.m. confirmed that no discussion had been held with him prior to the decision to quit allowing staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____ JUL 1 - 2013 MN Dept of Health Rochester	06/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(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 242	Continued From page 2 to get him up at 5:00 a.m. nor had there been any meeting with any [administrative] staff concerning the change since. No opportunity to be involved in the decision to alter the morning routine had been offered and/or allowed by administrative staff. During review of the activity assessment dated 5/14/13, which indicated the resident's daily preferences, it was noted that R18 had stated it was "very important" to him to choose his bedtime. Documentation also revealed it was "very important" to R18 to have family or close friend involved in discussions about his care, yet no discussion occurred with R18 concerning his schedule preference to choose when to get up in the morning. R25 failed to be provided the choice for bathing day or frequency of bath. R25 was admitted to the facility on 4/18/13. On 4/24/13 the facility conducted an admission Minimum Data Set (MDS) assessment that identified R25 with a Brief Interview for Mental Status (BIMS) score of 15 which indicated she had intact cognition. R25 was also identified free of any behavior indicators. During initial interview with R25 on 06/03/2013 at 4:48 p.m. she stated she did not get her choice for bath frequency and only received one bath a week. During interview with R25 on 6/4/13 at 9:28 a.m. she stated she would like to have more than one bath a week. R25 stated no-one had ever offered her the choice of more than one bath weekly. R25 stated when she was admitted she was told what	F 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	06/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

JUL 1 - 2013
Dept of Health
Rochester

(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 242	Continued From page 3 day her bath day would be. R25 stated she felt like she wasn't given the opportunity to voice her preference. During interview with the social service representative at the facility on 6/5/13 at 9:23 a.m. she stated residents should get a choice of their bath day and number of baths they prefer. During interview with the Director of Nursing Services (DON) on 6/5/13 at 1:00 p.m. she stated when residents were admitted to the facility staff was to ask them about their bathing preferences but did not specifically ask them day or frequency. The DON stated if a resident would like more than one bath a week they could have one.	F 242		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to document that alternative (non-pharmacological) interventions had been attempted prior to the administration of as needed (PRN) Haldol (anti-psychotic) for 1 of 1 resident (R41) who received PRN Haldol for behavioral symptoms. Findings include: The PRN Haldol had been administered five (5) times between 5/3/13 and 5/26/13 to R41 without documentation to indicate	F 282	SEE Attached	7/5/13 JPN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____ JUL 1 - 2013	06/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET Rochester HILLS, MN 56138

(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 282	Continued From page 4 that alternative interventions had been attempted prior to the use of the anti-psychotic medication, as stated in the plan of care. It was noted during record review that R41 had diagnoses that included Alzheimer ' s disease and dementia with behavioral disturbances. A physician order of Haldol 1 milligram (mg) every 4 hours PRN for agitation and physical aggression was received per telephone order on 5/3/13. The plan of care indicated that PRN Haldol to be given for physical aggression and agitation and repeated excessive restlessness after offering to toilet, walk in hallway, [and/or] move to another location. Review of the" behavior occurrences report" for R41 revealed the following: 5/3/13- resistive to ADL's [activities of daily living]; 5/17/13- resistive to ADL's; 5/18/13- resistive to ADL's; 5/22/13- sexual, rude, inappropriate remarks; and 5/26/13- resistive to ADL's. The electronic medical administration record (EMAR) indicated that Haldol (haloperidol) 1 mg had been given on the following dates and time: 5/3/13 at 13:49 [no description of behavior]; 5/17/13 at 17:10 for very aggressive and hitting staff; 5/18/13 at 17:15 for up and down up and down; 5/19/13 at 15:13 for up and down up and down; and 5/26/13 at 20:46 given for agitation and aggressive behavior toward staff. As with all EMAR dates that Haldol was given had not included the documentation to indicate what	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____ JUL 1 - 2013 MN Dept of Health Rochester	06/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(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 282	Continued From page 5 alternative interventions (identified in plan of care) had been attempted prior to the administration of the physician ordered PRN Haldol. Interview with the director of nurses (DON) on 6/4/13 at 3:30 p.m. verified that no further documentation was available for review to indicate that alternative interventions had been attempted as identified in the plan of care. The DON concurred that the narrative nursing notes lacked any mention of the behaviors exhibited by R41 during the times that PRN Haldol had been administered. The record lacked descriptive entries of resident behavior which required staff intervention and subsequent PRN Haldol (anti-psychotic medication) use.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor and assess 1 of 3 residents (R54) in the sample, reviewed for bruising. Findings included: R54 was observed on 06/03/2013 at 4:09 p.m. to	F 309	SEE Attachment	7/5/13 dpn

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____ JUL 1 - 2013 MN Dept of Health	06/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(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 309	Continued From page 6	F 309		

have a bruise at the top of her left forearm directly above her watch. The bruise was purple and yellow in color and looked like the shape of the residents watch. The resident's watch was noted to be quite tight on her arm. Although the resident required staff assistance for cares, no one had reported the bruise to the charge nurse for assessment.

R54's record was reviewed. She had been admitted to the facility 1/8/13 with diagnoses that included osteoarthrosis, congestive heart failure and atrial fibrillation. The quarterly Minimum Data Set (MDS) assessment dated 4/9/13 identified R54 as needing extensive assistance of staff with dressing, grooming and toileting and needing one staff assist with bathing. The resident's current physician's orders indicated the resident took the antidepressant medication Vivactil as well as aspirin daily both of these medications could cause bruising as a side effect. The plan of care dated 5/17/13 indicated R54 had skin impairment, had previously had bruises on 2/5/13 from a fall and one of the goals was that R54 "will have no further bruising thru review date." A skin risk score dated 1/11/13 identified R54 as having "multiple bruising to both right and left upper arms and bruising to left lower arm, above writs area." Review of the physician orders identified R54 as receiving numerous skin treatments to her legs, buttocks, and right arm twice daily. The bruise to her left wrist was not identified anywhere in the chart.

During interview with nursing assistant (NA)-E on 6/5/13 at 10:45 a.m. stated that she had given R54 a bath that morning. She stated she had not seen the bruise on the arm. She stated that staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____ JUL 1 - 2013	06/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET Rochester MN Dept of Health HILLS, MN 56138

(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 309	Continued From page 7 check the skin condition with cares daily as well as on bath days and then they report any changes to the skin to the nurse. During interview with registered nurse (RN)-A on 5/5/13 at 0:30 a.m. verified that skin checks are done on bath days as well as twice daily with cares and any bruising found should be reported to the nurse. She stated that R54 had previously had a bruise "just like this one" on admission. She verified that the bruise had not been reported and that the bruise looked like it could be from her watch as it was very tight.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide necessary care and services to maintain good personal hygiene for 1 of 1 resident (R25) who was noted to have strong body odor. Findings include: R25 who required extensive assistance with personal hygiene had ongoing body odor issues which were not addressed with more frequent bathing preferences to meet her specific hygiene needs. R25 was admitted to the facility on 4/18/13. On	F 312	SEE Attachment	7/5/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____ JUL 1 - 2013	06/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET Dept of Health Rochester HILLS, MN 56138

(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 312	Continued From page 8 4/24/13 the facility conducted an admission Minimum Data Set (MDS) assessment that identified R25 with a Brief Interview for Mental Status (BIMS) score of 15 which indicated she had intact cognition. R25 was also identified free of any behavior indicators and requiring extensive assistance of one staff with bathing. During initial interview with R25 on 06/03/2013 at 4:48 p.m. R25 stated she did not get her choice for bathing frequency and currently received one bath a week. During interview with R25 on 6/4/13 at 9:28 a.m. she stated she would like to have more than one bath a week. R25 stated no one from the facility had ever offered her the choice of more than one bath weekly. R25 stated when she was admitted she was told by the staff what day her bath would be. R25 then stated she felt like she wasn't given the opportunity to voice her preference for more than one bath a week. During the interview R25 was noted to have a strong body odor which was noted to be throughout the room. During interview with nursing assistant (NA)-A on 6/4/13 at 9:40 a.m. NA-A stated there was a smell of body odor frequently in R25's room and stated R25 would probably benefit from more baths. During interview with NA-B on 6/4/13 at 9:45 a.m. NA-B stated R25 always had a body odor smell. NA-A stated, "It's kind of her smell, she just smells that way." NA-B stated R25 would probably benefit from another bath each week. When NA-B was asked if she had ever addressed R25's body odor she stated she hadn't brought it to anyone's attention.	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____ JUL 1 - 2013 MN Dept of Health Survey Star	06/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(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 312	Continued From page 9 During interview with the social service representative at the facility on 6/5/13 at 9:23 a.m. she stated residents should get a choice of their bath day and number of baths they prefer. During interview with the Director of Nursing Services (DON) on 6/5/13 at 1:00 p.m. DON stated if a resident would like more than one bath a week they could have one. The DON verified if staff noted that a resident was having body odors she would expect the staff to bring it to the nurses attention.	F 312		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	SEE Attachment	7/5/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	06/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

JUL 1 2013
Dept of Health
Rochester

(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 329	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide medication monitoring for effectiveness for 2 of 10 residents (R29 and R41) reviewed for unnecessary medications. Findings include: R29 did not have timely blood monitoring to determine if the use of Lipitor (medication to reduce cholesterol in the blood) was effective or if other interventions were necessary. R29 was admitted to the facility 4/6/10 with diagnoses including hyperlipidemia (elevated cholesterol). Review of the physician orders showed R29 received Lipitor, 10 milligrams every day for hyperlipidemia (abnormally elevated levels of any or all lipids and/or lipoproteins in the blood.) The medical record revealed no blood monitoring (lipid panel) for R29's had been completed since 1/25/11 which was two and one-half years ago. Interview with registered nurse-B on 6/5/13 at 8:00 a.m. verified that no lipid panel had been done since 1/25/11. She stated it should have been done and a fax was sent to the physician for an order for a lipid panel to be checked. R41 was given as needed Haldol (antipsychotic medication with a warning that it is not	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	06/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

JUL 1 2013
MN Dept of Human Services Rochester

(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 329	Continued From page 11 recommended for elderly as it increases chance of death and tardive dyskinesia-a syndrome consisting of potentially irreversible , involuntary, movements) without documentation to indicate that alternative interventions of a non-pharmacological in nature had been attempted prior to the use of this high risk use of Haldol to control behaviors. Some of the alternative interventions were care planned. It was noted during record review that R41 had diagnoses that included Alzheimer's disease and dementia with behavioral disturbances. A physician order of Haldol 1 milligram (mg) every 4 hours PRN for agitation and physical aggression was received per telephone order on 5/3/13. The plan of care indicated that PRN Haldol to be given for physical aggression and agitation and repeated excessive restlessness after offering to toilet, walk in hallway, [and/or] move to another location. Review of the" behavior occurrences report" for R41 revealed the following: 5/3/13- resistive to ADL's [activities of daily living]; 5/17/13- resistive to ADL's; 5/18/13- resistive to ADL's; 5/22/13- sexual, rude, inappropriate remarks; and 5/26/13- resistive to ADL's. The electronic medical administration record (EMAR) indicated that Haldol (haloperidol) 1 mg had been given on the following dates and time: 5/3/13 at 13:49 [no description of behavior]; 5/17/13 at 17:10 for very aggressive and hitting staff; 5/18/13 at 17:15 for up and down up and down; 5/19/13 at 15:13 for up and down up and down;	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	06/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(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 329	Continued From page 12 and 5/26/13 at 20:46 given for agitation and aggressive behavior toward staff. As with all EMAR dates that Haldol was given had not included the documentation to indicate what alternative interventions (identified in plan of care) had been attempted prior to the administration of the physician ordered PRN Haldol. Interview with the director of nurses (DON) on 6/4/13 at 3:30 p.m. verified that no further documentation was available for review to indicate that alternative interventions had been attempted as identified in the plan of care. The DON concurred that the narrative nursing notes lacked any mention of the behaviors exhibited by R41 during the times that PRN Haldol had been administered. The record lacked descriptive entries of resident behavior which required staff intervention and subsequent PRN Haldol (anti-psychotic medication) use.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced	F 428	SEE Attachment	7/5/13 MP

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	06/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

JUL 1 - 2013

(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 428	Continued From page 13 by: Based on interview and record review, the pharmacist failed to identify the need for a lipid panel related to the use of a statin medication (Lipitor, a cholesterol lowering medication), for 1 of 10 residents R29 reviewed for unnecessary medications. Findings include: Laboratory values had not been monitored for R29 who utilized a statin medication that required blood work monitoring. R29 was admitted to the facility 4/6/10 with diagnoses including hyperlipidemia (elevated cholesterol). Review of the physician orders showed R29 received Lipitor 10 milligrams every day for hyperlipidemia. The medical record revealed no monitoring of R29's lipid panel had been completed since 1/25/11. A pharmacy recommendation dated 6/11/12 indicated "lipid panel should also be posted with use of Lipitor." During interview with the registered pharmacist on 6/5/13 at 12:00 p.m. verified that no lipid panel had been done since 1/25/11. He stated he had not readdressed the issue since his recommendation on 6/12/12.	F 428		

Tuff Memorial Home, Village And Apartments

LUTHERAN SERVICES IN AMERICA

Tuff Memorial Home,
Village and Apartments
505 East 4th Street
Hills, MN 56138-1017
Ph. 507-962-3275 or 3276

Date: June 25, 2013

JUL 1 - 2013

MN Dept of Health
Rochester

TO: Gary Nederhoff, Minnesota Department of Health

RE: Tuff Memorial Home, Hills, MN: Plan of Correction

From: Dana Dahlquist, Administrator

The following measures have been identified to correct this deficiency:

F 242 483.15 (b) Self Determination – Right to Make Choices

1. We will interview residents R18 and R25 and come up with a plan that will be mutually agreeable for their concerns about getting up early and bathing.
2. We offered R18 a chance to get up at 5:00 with night shift nurse aides but he wanted to wait for a specific nurse aide to get him up in the morning.
3. We will ask residents upon admission and quarterly thereafter about their preferences for daily routine and bathing.
4. We will educate nurse aides by July 5, 2013, on the importance of reporting to the charge nurse and/or Director of Nursing if a resident has body odor and is in need of more scheduled bathing.
5. The Director of Nursing, Charge Nurse and MDS Coordinator will monitor compliance with this correction.
6. The Tuff Memorial Home will be in compliance by July 5, 2013.

F 282 483.20 (k)(3)(ii) Services by Qualified Person/Per Care Plan

1. When an order is obtained for use of a PRN anti-psychotic med, the charge nurse will inform the Director of Nursing/Assistant Director of Nursing and/or the MDS coordinator.
2. We will identify specific parameters as to when to use anti-psychotic medications.
3. We will care plan parameters for the use of anti-psychotic medications usage.
4. We will education professional staff by July 5, 2013, regarding the need to have parameters placed on the care plan for the use of PRN anti-psychotic medications.
5. The Director of Nursing, Assistant Director of Nursing and MDS Coordinator will monitor the use of anti-psychotic medications.
6. We will be in compliance by July 5, 2013.

F 309 483.25 Provide Care/Services for Highest Well Being

1. We will write out reports on non-pressure related skin concerns.

2. A policy will be written on skin care regarding non-pressure related skin concerns.
3. We will provide an in-service to staff by July 5, 2013, regarding timely reporting of non-pressure related skin conditions.
4. The Director of Nursing and Assistant Director of Nursing will monitor this.
2. The Tuff Memorial Home will be in compliance by July 5, 2013.

F 312 483.25(a)(3) ADL Care Provided for Dependent Residents

1. Residents will be given the opportunity to make choices about aspects of his or her life in the facility that is significant to the resident.
2. Residents will be interviewed on Admission regarding preferences and quarterly thereafter.
3. We will interview R25 to find out his/her preference for bathing.
4. We will educate nurse aides BY July 5, 2013, on the importance of reporting to the charge nurse and/or Director of Nursing if a resident has body odor and is in need of more scheduled bathing.
5. The Director of Nursing and Charge Nurse will monitor compliance with this correction.
6. The Tuff Memorial Home will be in compliance by July 5, 2013.

F 329 483.25 (i) Drug Regimen is Free From Unnecessary Drugs

1. When an order is obtained for use of a PRN anti-psychotic medication the charge nurse will inform the Director of Nursing/Assistant Director of Nursing and/or MDS Coordinator.
2. We will identify specific parameters when to use anti-psychotic medication.
3. We will care plan parameters for use of anti-psychotic mediation.
4. We will check with Medical Director for parameters on checking the effectiveness of statin medication.
5. We will provide education to our professional staff by July 5, 2013, on the use of anti-psychotic and statin medication.
6. The Director of Nursing/Assistant Director of Nursing and MDS Coordinator will monitor our compliance with this.
7. The Tuff Memorial Home will be in compliance by July 5, 2013.

F 428 483.60 (c) Drug Regimen Review

1. When an order is obtained for use of a PRN anti-psychotic medication the charge nurse will inform the Director of Nursing/Assistant Director of Nursing and/or MDS Coordinator.
2. We will identify specific parameters when to use anti-psychotic medication.
3. We will care plan parameters for use of anti-psychotic mediation.
4. We will check with Medical Director for parameters on checking the effectiveness of statin medication.
5. We will provide education to our professional staff by July 5, 2013, on the use of anti-psychotic and statin medication.
6. The Director of Nursing/Assistant Director of Nursing and MDS Coordinator will monitor our compliance with this.
7. The Tuff Memorial Home will be in compliance by July 5, 2013.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/11/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	**505 EAST 4TH STREET HILLS, MN 56138**

(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 A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. on June 11, 2013. At the time of this survey, Tuff Memorial Home was found to be 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) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. Tuff Memorial Home was constructed as follows: The original building was constructed in 1959, is one-story, has a partial basement, is fully fire sprinkler protected and is of Type II(111) construction; The 1st Addition was constructed in 1962, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 2nd Addition was constructed in 1975, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 3rd Addition was constructed in 1988, is one-story, has a full basement, is fully fire sprinkler protected and is of Type V(111) construction; The 4th Addition was constructed in 1998, is one-story, has no basement, is fully fire sprinkler protected and is of Type V(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. There are two-hour fire walls equipped with labeled 90-minute fire door assemblies, separating the buildings of Type	K 000		

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

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
	245548	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/11/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	**505 EAST 4TH STREET HILLS, MN 56138**

(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 1 II(111) construction from the additions of Type V(000) construction. The facility has a capacity of 50 beds and had a census of 44 at time of the survey. Because the original building and the four additions met the construction types allowed for existing buildings, the facility was surveyed as one building, and one (1) Form CMS-2786R booklet was completed.	K 000		