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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: C2TI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00073

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245499**
2.STATE VENDOR OR MEDICAID NO.
(L2) **190176100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CALEDONIA CARE AND REHABILITATION CENTER**
(L4) **425 NORTH BADGER STREET**
(L5) **CALEDONIA, MN** (L6) **55921**

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) **07/01/2004**

6. DATE OF SURVEY **10/20/2014** (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:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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):

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 10/20/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/22/2014 (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
10/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245499

October 22, 2014

Ms.. Marian Rauk, Administrator
Caledonia Care And Rehabilitation Center
425 North Badger Street
Caledonia, Minnesota 55921

Dear Ms.. Rauk:

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 October 19, 2014 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,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

October 22, 2014

Ms. Marian Rauk, Administrator
Caledonia Care And Rehabilitation Center
425 North Badger Street
Caledonia, Minnesota 55921

RE: Project Number S5499021

Dear Ms. Rauk:

On September 18, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 4, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On October 20, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 20, 2014 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 September 4, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 19, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 4, 2014, effective October 19, 2014 and therefore remedies outlined in our letter to you dated September 18, 2014, 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,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

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
245499	A. Building B. Wing	10/20/2014

Name of Facility	Street Address, City, State, Zip Code
CALEDONIA CARE AND REHABILITATION CENTER	425 NORTH BADGER STREET CALEDONIA, MN 55921

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 **F0241** Reg. # **483.15(a)** LSC	Correction Completed **10/14/2014**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **10/14/2014**	ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **10/14/2014**
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **10/14/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **10/14/2014**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **10/14/2014**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **10/14/2014**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **10/14/2014**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **10/14/2014**
ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **10/14/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **10/14/2014**	ID Prefix **F0456** Reg. # **483.70(c)(2)** LSC	Correction Completed **10/14/2014**
ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **10/14/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GKN/KFD	10/22/2014	10160	10/20/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
9/4/2014			

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
245499	A. Building B. Wing **01 - THE LUTHERAN HOME CALEDONIA**	10/20/2014

Name of Facility	Street Address, City, State, Zip Code
CALEDONIA CARE AND REHABILITATION CENTER	425 NORTH BADGER STREET CALEDONIA, MN 55921

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	Correction Completed **10/15/2014**	ID Prefix	Correction Completed **10/19/2014**	ID Prefix	Correction Completed **10/19/2014**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0029		LSC K0045		LSC K0050	
ID Prefix	Correction Completed **10/19/2014**	ID Prefix	Correction Completed **10/19/2014**	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. #	
LSC K0056		LSC K0144		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/KFD	10/22/2014	25822	10/20/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 9/8/2014

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: C2TI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00073

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245499**
2.STATE VENDOR OR MEDICAID NO.
(L2) **190176100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CALEDONIA CARE AND REHABILITATION CENTER**
(L4) **425 NORTH BADGER STREET**
(L5) **CALEDONIA, MN** (L6) **55921**

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) **07/01/2004**

6. DATE OF SURVEY **09/04/2014** (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):

17. SURVEYOR SIGNATURE Date :
Josephine Hassinger, HFE NE II 10/06/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/22/2014 (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
10/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

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 1060 0002 3051 2880

September 18, 2014

Ms. Marian Rauk, Administrator
Caledonia Care And Rehabilitation Center
425 North Badger Street
Caledonia, Minnesota 55921

RE: Project Number S5499021

Dear Ms. Rauk:

On September 4, 2014, 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;

<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
gary.nederhoff@state.mn.us
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 October 19, 2014, 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 October 19, 2014 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 December 4, 2014 (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 March 4, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
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

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 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Enclosure

cc: Licensing and Certification File

OCT 3 2014
MN Dept of Health
Rochester

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245499	A. BUILDING _____ B. WING _____	09/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALEDONIA CARE AND REHABILITATION CENTER	425 NORTH BADGER STREET CALEDONIA, MN 55921

(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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to enhance the resident ' s self-worth and self-esteem by providing and environment that promotes dignity for 2 of 2 residents (R28 and R53) who did not receive services that promoted dignity. Findings include: R28's quarterly Minimum Data Set (MDS) dated 5/28/2014 revealed R28 had diagnoses of Dementia, Depression, Parkinson's disease and Anxiety Disorder. R28 had severe cognitive impairment and was rarely/never understood. R28 required total dependence with two staff with	F 241	Caledonia Care & Rehab does promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. 10-05-14 GPI 1. R53- A review of the bladder record shows that he had one incontinence episode on 9.3.14. R53 initiated call light 33 times on 9.3.14 with wait time average of 4 min. and 6 seconds resulting in 97% of R53s call light being answered without going into extended wait time. One call light,	

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

Marian Rauk | Administrator | 10.2.14

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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OCT 3 2014
MN Dept of Health
Rochester

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F 241	Continued From page 1 bed mobility, transfers, dressing, bathing, toilet use, and personal hygiene, total dependence of one staff for locomotion on and off the unit and for eating. The care plan dated 4/14/14 indicated R28, "Can respond at times appropriately to simple questions, but doesn't always do so." During an interview on 9/2/14 at 6:41 p.m., when asked if staff treat R28 with respect and dignity, family members (FM)-A and FM-B answered, "No. Sometimes we have concerns about [R28's] clothes. We will come and visit and [R28's] skin will be exposed. FM-A and FM-B gave example of R28's pants not being pulled up correctly. FM-A and FM-B stated, "We have talked to them [staff] about this and treating [R28] with dignity." During an observation on 9/3/14 at 1:03 p.m., licensed practical nurse (LPN)-C verified R48 was sitting in the recliner in R28's room and stomach skin was exposed above R28's pants. LPN-C stated staff should have positioned R28's clothing to not expose the stomach skin, and verified R28 was unable to adjust the shirt on their own. LPN-C verified having stomach skin exposed was a dignity concern. During an interview on 9/3/14 at 4:10 p.m., the administrator stated she expected staff to rearrange clothing to prevent skin from being exposed after using the lifts and after repositioning residents. The administrator verified residents having stomach skin exposed was a dignity concern. A policy was requested on caring for residents with respect and dignity. The facility did not provide a facility policy, however provided a copy of an excerpt from the facility website that read,	F 241	during the night time hours, was just over ten minutes. During the time R53 was documented as incontinent, five of the six call lights were answered in less than five minutes. The call over five minutes, R53 was in the bathroom waiting for assist to get off the toilet and this was a seven minute wait. Resident stated he called the facility, home, and son in Texas during this wait time. The average wait time did not allow for all of those calls to be made. During extended wait times, R53 did not experience incontinence, but had an incontinent episode when there was no extended wait time. In August, the Social Worker did a compilation of call light usage for R53 and found an average of 32 calls a day where an average for other residents was 10 in a 24-hour period. The Social Worker documented in her note on 8.27.14 that in the six days she reviewed, the	

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F 241	Continued From page 2 "We are committed to providing an environment in which all people are treated with kindness, dignity and respect, no matter their physical impairment or mental condition." The resident bill of rights dated 7/1/07, directed the, "Facility must with courtesy promote and care for you in a manner and environment that maintains or enhances your dignity and respect in full recognition of your individuality." R53's admission MDS assessment, dated 5/23/2014, indicated intact cognition. The MDS further indicated R53 required extensive assistance from staff, with the physical assistant of one, for toileting and dressing, and the physical assistance of two persons for transferring. During an interview on 9/4/2014 at 9:49 a.m., R53 stated he had, "an accident yesterday" on asking what he meant by accident R53 said that he soiled himself because he did not receive timely assistance to toilet. R53 said he had just returned to the nursing home after an outing in the morning, went to his room and put the call light on and waited. R53 said he "wet himself " with urine because he had to wait too long for assistance. R53 then said he had to use the bathroom a second time later that morning, and went into the bathroom without staff assistance. R53 said, "I pushed the [call] light on, after I was on the toilet." R53 stated he was not to use the toilet without staff help. R53 said he has fallen asleep in his chair waiting for staff to come and answer a call light. R53 said he had waited so long for assistance after activating the call light without staff response, that he called the nursing home phone with his personal telephone to request assistance. R53 added that he has also "called home " and " called my son in Texas " and had them call the nursing home, letting staff	F 241	average wait time ranged from 3min. 30sec to 5min 30sec. R53 behavior called for an adjustment in care plan, both on August 14 and August 20, 2014. Call light usage on 9.3.2014 indicated nine of the 33 calls with over five minute wait times, and three of the nine R53 was in the bathroom waiting to be assisted off of toilet. Behavior charting indicates R53, at times, does not allow staff time to respond to call light prior to initiating a call to the front desk for assistance. R53 has also called the front desk when staff was standing ready to assist him. R 53 will continue to be assisted to the bathroom per his demand, as soon as staff is available to meet his needs. During a survey correction plan meeting, several staff noted resident R28 consistently does, on an involuntary basis, bring in and slide right forearm upward against shirt, and because of rigidity in that extremity, this	

OCT 3 - 2014
MN Dept of Health
Rochester

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F 241	Continued From page 3 know I wanted help. R53 said, "I believe they [the nursing home] have too many residents here for the number of staff they have." During an interview on 9/4/2014 at 9:44 a.m., nursing assistant (NA)-B stated that "by and large" we do get our toileting an repo [repositioning] completed, and on time. " NA-B acknowledged that there were times when residents had accidents, because staff could not assist them as quickly as needed. Then NA-B said, "That's likely what happened with [R53], and that should not have happened." During an interview on 9/4/2014 at 3:36 p.m., LPN-B stated residents needed to be toileted in a timely manner, and agreed soiling oneself is not acceptable. LPN-B stated, "It is a matter of dignity for a resident." In an interview on 9/4/2014 at 4:30 p.m., the director of nursing (DON) stated, that each resident should receive assistance as needed.	F 241	causes shirt to rise, exposing her stomach area. R28- clothing will be observed closely and adjusted to assure stomach is covered at all times. 2. An audit of residents with potential to need assistance with toilet use and/or clothing adjustments was completed. Education was provided reiterating the importance of the need to respond to call lights in a timely fashion for all residents, and to assure residents are dressed in a dignified manner. 3. Education will be provided to all staff to ensure they are aware of the need to follow through with residents' requests and needs per care plan. 4. Audits will be completed weekly to assure toilet use and dignity is provided to all residents for a month and then quarterly for one year. 5. Completion date is October ~~19, 2014.~~ 30, 2014	10-14-14 GPN
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, observation and document review the facility failed to follow identified family preferences related to care for 1 of 1 resident	F 242		

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F 242	Continued From page 4 (R28) reviewed for choices. Findings Include: R28's quarterly Minimum Data Set (MDS) dated 5/28/2014 revealed R28 had diagnoses of Dementia, Depression, Parkinson's disease and Anxiety Disorder. R28 had severe cognitive impairment and was rarely/never understood. R28 required total dependence with two staff with bed mobility, transfers, dressing, bathing, toilet use, and personal hygiene, total dependence of one staff for locomotion on and off the unit and for eating. The care plan dated 4/14/14 indicated R28, " Can respond at times appropriately to simple questions, but doesn't always do so." Review of progress note dated 6/3/13 read, " SPECIAL REQUEST: give meals at 8:30 am, 12:30 pm and 4:30 pm. All meals served in own room or east alcove area for 'quiet environment to promote optimal intake'. Resident is assisted with oral foods/fluids and supplement intake." R28's care plan and nursing assistant assignment card were reviewed and did not address what time in the morning family had requested R28 to be up for the day or what times family had requested R28 to have meals. During an interview on 9/2/14 at 6:33 p.m., family members (FM)-A and FM-B were asked, " Does [R28] get up in the mornings according to his/her previous routine?" FM-A and FM-B answered, " No. We would like [R28] to have [R28's] Parkinson medication around 8:00 a.m. and be out of bed around 8:30 a.m. in the morning. There have been times when we have come to visit and it has been 9:30 a.m. to 10:00 a.m. and	F 242	Caledonia Care & Rehab promotes residents to choose activities, schedules, and health care consistent with his or her interests, assessment, and plans of care; interact with members of the community both inside and outside the facility; and make choices regarding aspects of his or her life in the facility significant to the resident. 1. Staff will continue to do their best to meet the recommendations of family regarding scheduling for R28. We strive to meet the requests of all residents and the families meanwhile assuring safety of all residents resulting in the need to vary schedules at times. We do have a rise upon waking policy and R 28 does not present in a manner that does indicate being tired, typically not waking unless stimulation is provided, and known to fall asleep during meals/activities. The	

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F 242	Continued From page 5 [R28] is still in bed, partially dressed but not up." FM-A and FM-B stated they have discussed these preferences with staff and it continues to be a concern. They stated they have addressed these concerns during care conferences and address these concerns immediately with the staff working when they visit and she is still in bed at 9:30 a.m. to 10:00 a.m. when they arrive at the facility. FM-A and FM-B also voiced a concern related to R28 not receiving meals at the same time other residents received their meals in the dining room and stated there had been times when R28 was served after the clean-up of the meal had already been completed in the dining room. FM-A and FM-B stated they had voiced their concerns regarding resident being served later than other residents and their preferences for R28's meals times with facility staff. During an interview and observation on 9/3/14 at 9:20 a.m. nursing assistant (NA)-B stated she provided morning cares and got R28 dressed around 7:30 a.m. that morning, and stated R28 remained in bed at that time. NA-B stated at 9:20 a.m. they finished R28's cares and were getting R28 up for the day. NA-B stated R28 had breakfast at table in hall per family preference and stated the time of breakfast varied as R28 needed to take Parkinson's medication and had to wait thirty minutes after receiving the medication to eat. NA-B stated staff got R28 up around this same time approximately 9:30 a.m. on a regular basis. When NA-B was asked if she was aware of a family preference for a time for R28 to get up in the morning, NA-B stated, " They would like [R28] up earlier but they are not able to get [R28] up earlier if we are busy with the other residents." And stated she thought family	F 242	correction regarding R28 scheduling will not be significant as staff have been diligently attempting to be successful in meeting family requests prior to survey as well as the fact it does take one to one and a half hours for resident to eat a meal on a more "alert" day leading staff to begin assisting with breakfast as early as possible. Communication will be established with family regarding any need for change in schedule. 2. All residents with severe cognitive impairment will be evaluated to assure that, per responsible party, their needs and desires are followed through on as requested. 3. Education will be provided to staff regarding the need to make every effort to meet requests of residents or responsible party regarding the needs of a resident.	

OCT 3 2014
MN Dept of Health
Rochester

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F 242	Continued From page 6 would like R28 up for the day at 9 a.m. in the morning. NA-A was also present in the room at the time of the interview and observation stated she thought family wanted R28 up for the day by "10:00" a.m. and stated R28 received the Parkinson's medication at 8:00 a.m. in the morning. During an observation on 9/3/14 at 9:48 a.m., NA-B was observed to be assisting R28 to eat breakfast. During an observation on 9/3/14 at 11:47 a.m., R28 was observed to be sitting in the east alcove area in a Broda chair slightly reclined with eyes closed. During an observation on 9/3/14 at 12:08 p.m., R28 was observed to be sitting in the east alcove area in a Broda chair slightly reclined with eyes closed. R28 had not been observed to have lunch. During an observation on 9/3/14 at 12:45 p.m., R28 was observed to be in the recliner in R28's room with eyes closed and the lights in the room turned off. R28 had not been observed to have lunch. During an observation on 9/3/14 at 1:29 p.m., R28 was observed to be in the recliner in R28's room with eyes closed and the lights in the room turned off. R28 had not been observed to have lunch. During an observation on 9/3/14 at 1:38 p.m., R28 was observed to be in the recliner in R28's room with eyes closed and the lights in the room	F 242	4. Audits will be completed by DON/designee to assure that all residents choices are met as requested per resident and/ or family. Audits will be completed weekly for one month and monthly for three months, and then quarterly. Information will be shared with Quality Assurance & Assessment Committee on a quarterly basis. 5. Completion date: October 19, 2014.	

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F 242	Continued From page 7 turned off. R28 had not been observed to have lunch. During an observation on 9/3/14 at 1:40 p.m. the licensed social worker (LSW)-A was observed to enter R28 to complete a social service visit. During an observation and interview on 9/3/14 at 1:47 p.m. NA-E was observed to assist R28 to eat lunch. NA-E stated R28, " normally had lunch between 1:00 and 1:30 p.m." and stated R28 would have supper around 5:00 p.m. that evening. NA-E stated R28's, "eating times were different than the other residents in the facility because of family preferences." NA-E stated family wants R28, " up early by 8:30 a.m. or someone in there. I know they have requested her to be up early. NA-E stated, " Family wanted [R28] to eat breakfast around 10:00 a.m." NA-E stated staff was made aware of family preferences for resident cares verbally through report. During an observation and interview on 9/3/14 at 1:55 p.m. registered nurse (RN)-A verified R28 was being assisted to eat lunch at 1:56 p.m. and verified documentation of family request for R28 to have meals at 8:30 a.m., 12:30 p.m. and 4:30 p.m. During an observation and interview on 9/4/14 at 9:17 a.m., NA-C and NA-D were observed to be getting R28 out of bed for the day. NA-C stated she normally got R28 up for the day between 8:30 a.m. and 9:00 a.m. in the morning. NA-C stated staff went by R28's two hour turning schedule and when R28 received her Parkinson's medication for when they got R28 up for the day and for the time R28 received meals. NA-C stated if family	F 242		

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F 242	Continued From page 8 had a preference for meal times or time of the day for R28 to get up for the day the preference would listed on the nursing assistant care plans. NA-C stated R28 was to have lunch around 12:30 p.m. During an observation on 9/4/14 at 10:00 a.m. R28 was observed to be having breakfast. During an interview on 9/4/14 at 9:47 a.m. the administrator stated she was unaware family had requested specific meal times and a specific time in the morning for staff to get R28 up for the day. The administrator stated she expected residents to be served lunch before 2:00 p.m. and stated meals should be served to R28 by the schedule that has requested by family and stated staff should get R28 out of bed in the morning by the time the family has requested. During an observation on 9/4/14 at 1:20 p.m., R28 was observed to be having lunch. During an interview on 9/4/14 at 2:31 p.m. the director of nursing (DON) stated if there was a family request for a resident to eat meals at specific times or for a resident to get out of bed in the morning at a specific time, the facility should try to try to accommodate these requests and have the resident eat close to the requested times and get out of bed in the morning close to the requested time. The DON stated she was unaware of specific family requests for R28 to get out of bed for the day in the morning or specific time ' s family had requested R28 to have meals. The DON stated when family makes specific requests related to residents' cares the specific requests should be added to the residents ' care plan for staff to follow. The DON verified R28's	F 242		

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F 242	Continued From page 9 family requests for meal times and when to get R28 out of bed in the morning were not on the care plan. A facility policy was requested on resident ' s choices and was not provided.	F 242		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain a clean room for 1 of 1 resident (R28) identified by family as not having a clean room. Findings include: During an interview on 9/2/14 at 7:00 p.m., when asked, " Is the building clean? " family members (FM)-A and FM-B answered, " No, the furniture is dusty; the nursing assistants are to clean residents ' rooms along with their other responsibilities." FM-A took her finger and swiped it across the china cabinet in R28's room to demonstrate the china hutch was covered with dust and there was a buildup of dust noted on the china hutch. FM-A and FM-B stated they had shared these concerns with facility staff. Review of a progress noted dated 6/12/14 at 2:57 a.m. and 11:30 a.m., revealed family members had visited R28 yesterday evening and were very	F 253	Caledonia Care & Rehab does provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. 1. Room for R28 was swept and mopped prior to surveyor's leaving the building. China hutch was dusted. 2. A schedule was drawn up for room maintenance. Schedule will be posted and followed for all residents. Housekeeping did review our product list and made suggestions for changes where appropriate. 3. We are reviewing rooms getting a schedule set up for monitoring cleanliness. In our new electronic charting program we will set up a To Do List for cleaning. A monitor list will be set up.	

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F 253	Continued From page 10 upset and stated R28's room was dirty. During an interview on 9/4/14 at 9:17 a.m. nursing assistant (NA)-C verified the floor in R28 ' s room was " dirty " and needed to be swept and the china cabinet was dusty. NA-C stated she, " tried to clean resident rooms when residents were in activities between 1:30 p.m. and 2:00 p.m." NA-C stated that gave her, "thirty minutes to clean eight residents rooms" on her assigned wing during her shift. NA-C stated room cleaning was the task that she was assigned that, "doesn't get done the most." During an interview on 9/4/14 at 9:47 a.m. the administrator verified the floor in R28's room was soiled with debris and needed to be swept and the china cabinet was dusty. The administrator stated the staff should sweep and mop the floor one to two times a week and stated, "Sweeping should be done whenever there is soiling." The administrator stated the china cabinet should be dusted on a weekly basis. The administrator stated the person that was caring for the resident was responsible for cleaning their room. The administrator also stated the housekeeping supervisor and her assistant who just started on Tuesday were also responsible to clean resident rooms. The administrator stated the facility had been without an assistant housekeeper all summer and explained the assistant housekeeper's roll was to assist with sweeping and dusting in resident rooms. The administrator stated the facility worked off of the household model. The administrator stated she was aware of the concerns with residents' room being clean and stated the facility was working on this. The administrator stated she was aware of concerns related to the cleanliness of R28's room as the	F 253	4. Audits will be completed by housekeeping supervisor on a monthly basis, checking to ensure the desires of the resident and families regarding cleanliness of rooms are met. These audits will be shared with the Quality Assurance & Assessment Committee. 5. Completion date: ~~October 19, 2014.~~ 10-14-14 GPM	

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	245499	A. BUILDING _____ B. WING _____	09/04/2014

OCT 3 2014
MN Dept of Health
Rochester

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F 253	Continued From page 11 family had voiced concerns and verified there was documentation of family concerns in progress notes dated June 12, 2014 and stated audits had been completed by the director of nursing related to the cleanliness of R28 ' s room. The administrator stated to her knowledge there had been no further concerns after the audits had been completed. The policy titled Caledonia Care and Rehab Housekeeping Program Policy and Guidelines dated 4-2014 read, " Policy: Caledonia Care and rehab will provide a safe, sanitary and comfortable environment. Guidelines: 1. Direct Care professionals utilize the cleaning schedules as provided in the "housekeeping daily task books" as part of the housekeeping program ..."	F 253		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under	F 279	Caledonia Care & Rehab does use the results of assessments to develop, review and revise the resident's comprehensive care plan. 1. R59's care plan was completed on 9.15.14 addressing anticoagulant and diuretic medications. 2. All care plans were reviewed to assure anticoagulant and diuretic medications were addressed including the usage and monitoring of side effects. This was completed by September 30, 2014.	

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F 279	Continued From page 12 §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to develop a care plan to address the use of an anticoagulant (Coumadin) and diuretic (Lasix) medication for 1 of 5 residents (R59) reviewed for unnecessary medications. Findings include: R59's significant change Minimum Data Set (MDS) dated 6/18/14, identified diagnoses which included congestive heart failure, and hypertension. The MDS also identified R59 received an anticoagulant 6 days and a diuretic 7 days out of the 7 day assessment period. The current physicians orders identified R59 received Lasix 20 mg (milligrams) daily, and Coumadin 2.5 mg daily on Monday, Wednesday and Friday, and 5 mg Tuesday, Thursday, Saturday, and Sunday. During an interview on 9/4/14, at 1:33 p.m. licensed practical nurse (LPN)-B confirmed R59's care plan did not address Coumadin or Lasix medication use. LPN-B did not identify specific side effects that would be monitored with use of Coumadin or Lasix. During an interview on 9/4/14, at 2:19 p.m. registered nurse (RN)-B confirmed R59's care plan did not address the use or monitoring of potential side effects of Coumadin and Lasix, and stated the medications should have been "care planned for the body system " it effects.	F 279	3. Caledonia Care & Rehab will review medication list to assure side effects of medications are appropriately addressed in the care plan for all residents. 4. Audits will be completed by the DON/designee for new admission medications, as well as those who have a medication change that requires identification in the care plan. Audits will be done on admission, monthly for three months, and quarterly for one year. 5. Completion date: October 19, ~~2014.~~ 2015 10-14-14 GPN	

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F 279	Continued From page 13 During an interview on 9/4/14, at 3:53 p.m. the director of nursing (DON) confirmed R59's current care plan. The DON stated R59's care plan should address "cardiovascular, edema, and lab [laboratory]" work for residents utilizing Coumadin and Lasix and should be "care planned for side effects." During a returned phone call on 9/5/14, at 1:40 p.m. the consulting pharmacist (CP)-A confirmed residents with Coumadin should be monitored for side effects which included bleeding, easy bruising, hematuria (blood in the urine), and tarry stools, and Lasix monitoring would include dehydration and excess fluid loss. CP-A stated "It would be reasonable" to have primary side effects of these medications documented for staff awareness. The requested facility policy and procedure regarding anticoagulant and diuretic use was not provided.	F 279		
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 observation, interview, and document review, the facility failed to implement resident care plan interventions to promote healing and/or prevent increase of a current pressure ulcer for 1	F 282	F 282 Caledonia Care & Rehab does provide a qualified person to perform needed duties for the resident's written plan of care. 1. R3, R7, and R12's care plans were reviewed for repositioning and range of motion.	

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

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F 282	Continued From page 14 of 3 residents (R3) reviewed with a pressure ulcer, in addition the facility failed to implement the care plan range of motion services for 3 of 3 residents (R3, R7, R12) reviewed who received these services. Findings include: LACK OF SERVICES AND CARE TO PROMOTE HEALING AND PREVENTION OF PRESSURE ULCER/S: R3 had not been repositioned for 2 hours and 34 minutes even though R3 had a stage three pressure ulcer on her coccyx and was assessed to need repositioning to relieve pressure on the ulcer are every 1.5 hours. R3's care plan revised 6/24/14, identified R3 had "impaired skin integrity," and had a repositioning schedule of 1.5 hours when in bed and a check and change of incontinent liners every 2 hours. The quarterly Minimum Data Set (MDS) dated 8/6/14; identified R3 had a stage 3 pressure ulcer (full thickness tissue loss, exposing the subcutaneous tissue) and, was incontinent of bowel and bladder. During an interview on 9/4/14 at 7:07 a.m. nursing assistant (NA)-K confirmed nursing assistants logged the time residents were provided cares and used the computer to track the next time care was to be provided. NA-K confirmed R3 was scheduled to receive care of toileting and/or repositioning at 7:53 a.m. During observations on 9/4/14, at the following times: 7:06 a.m. R3 was in bed positioned on her back	F 282	2. Education was given to all staff on the importance of adhering to the care plan. The importance of following the care plan reiterating the turning and repositioning guidelines and range of motion for all residents. 3. We have spoken with our therapy providers and they developed a range of motion video for us to use as a training module to reiterate the importance of range of motion and repositioning. We will use this DVD as part of the education of staff. 4. Audits will be completed by DON/Designee to assure that repositioning, turning and range of motion is being completed as directed by care plan. This will be done monthly for three months, and quarterly thereafter. 5. Completed by ~~October 19, 2014.~~ 10/20	10-14-14 GPN

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F 282	Continued From page 15 with a pillow under the right side of her body. 8:25 a.m. R3 remained on her back with the pillow in the same position. 8:29 a.m. R3 remained in same position. 8:49 a.m. R3 remained in the same position. 8:49 a.m. continuous observation of R3 began. R3 remained in the same position on her back with the pillow under her right side, with no staff entering the room until 9:40 a.m. when NA-H entered the room to provide morning cares. R3's incontinent liner was saturated with urine and a 2 inch square dressing was in place on the coccyx which was soiled on one edge with sanguineous (containing blood) drainage. During an observation on 9/3/14, at 1:40 p.m. licensed practical nurses (LPN)-B, along with NA-H performed a dressing change to the ulcer. The ulcer was circular, with a diameter of 2 centimeters; the tissue was " beefy " red in color with a pink scarred area around the perimeter. During an interview on 9/3/14, at 10:07 a.m. NA-H confirmed staff had not checked, changed or repositioned R3 this morning, and this was a typical morning for R3. NA- stated the "6 o'clock person does rounds in the morning" and confirmed at 9:40 a.m. was the first time NA- had entered R3's room to do cares. During an interview on 9/3/14 at 1:40 p.m. LPN-B stated staff is expected to check and change incontinent products and reposition R3 when in bed every 2 hours (however, the care plan says every 1.5 hours.) During an interview on 9/4/14, at 2:23 p.m. registered nurse (RN)-B, stated staff is expected to follow care plan to reposition and check and	F 282		

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F 282	Continued From page 16 change residents. During an interview on 9/4/14 at 3:53 p.m. the director of nursing (DON) confirmed staff are expected to follow the care plan to check, change and reposition residents. LACK OF RANGE OF MOTION SERVICES AS DIRECTED BY THE CARE PLAN: R3's care plan revised 7/11/14, identified R3 had impaired physical mobility, and had a restorative program that included, passive range of motion exercises including arm extensions, wrist flexion and extension, heel cord stretches, hamstring stretches, and knee bends for 12 to 15 repetitions with each exercise for a total of 15 minutes daily. The quarterly minimum Data Set (MDS) dated 8/6/14, identified R3 had impaired functional limitation in range of motion to both sides of the upper and lower body, had total dependence on staff for all areas of daily living (ADL). Review of the range of motion (ROM) charting lacked any documentation that services were performed in the past 6 days. During an interview on 9/3/14, at 10:07 a.m. NA-H confirmed she had not performed ROM exercises for R3 and, stated nursing assistants do not do exercises or range of motion for the residents, "a rehab (rehabilitation) aid does them." R7 ' s care plan revised 6/17/14 identified R7 had left sided hemiparesis, and a restorative program of ROM to arms and legs daily. The quarterly MDS dated 6/4/14, identified R7 had functional limitation in range of motion impairment on one side of the body, upper and lower and required	F 282		

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F 282	Continued From page 17 extensive assistance with activities of daily living. During an interview on 9/4/14, at 4:15 p.m. R7 confirmed no exercise or ROM services were completed for her arm or legs today. Review of the ROM charting lacked documentation that services had been completed for the past 6 days. During an interview on 9/4/13, 8:36 a.m. NA-E stated, "We do not have enough staff," since some staff returned to school and others have quit. " NA-E confirmed 2 rehab aids perform all exercise and ROM services. NA-E explained due to the shortage of staff, the rehab aids are moved into the nursing assistant position and no one performed the ROM services. During an interview on 9/4/14, 2:21 p.m. RN-B confirmed ROM services for R3 and R7 were scheduled to be completed daily. RN-B stated when a rehab aid is needed to work as a nursing assistant "we don't have someone to cover that now," in regards to rehab aid doing ROM for residents so it is not completed. During an interview on 9/4/14 at 3:53 p.m. the DON confirmed the resident care plan for daily range of motion should be followed by staff. The DON stated if the rehab aid was pulled from the floor all staff should work together to complete all cares for residents include the daily ROM services. A requested facility policy was not provided in regards to ROM services. R12 was not provided ROM services as directed on the comprehensive care plan.	F 282		

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F 282	Continued From page 18 The physician visit dated 7/22/14 indicated that R12's diagnoses included cerebrovascular accident (CVA), depression, hemiplegia, diabetes mellitus and coronary artery disease. R12's restorative plan of care dated 7/11/14 indicated that R12 had limited range of motion to the right leg related to her CVA. Instructions included assisting resident to apply knee brace to right side for up to 1 hour daily to aide in stretching of the knee and hamstring. The total time brace was left on was to be documented. The level of extension in degrees R12 was able to perform was to be documented. Documentation of the restorative nursing charting for R12 for August, 2014 and September, 2014 was reviewed. There was no documentation of restorative nursing from 8/1/14 through 8/7/14. There was no documentation of restorative nursing being completed from 8/23/14 to 9/4/14. An interview on 9/3/14 at 1:19 p.m. with the physical therapy aide, (PTA) indicated that R12 was discharged from therapy on 8/28/14 and given to nursing to complete exercises. The PTA indicated that R12 was to be on a sit and glide restorative program 15 minutes each day. Review of the discharge summary from physical therapy dated 8/29/14 read that physical therapy's last visit was 8/28/14. R12 would be set up on restorative with Sit-Glide and right knee extension passive range of motion exercise. During an interview on 9/4/14 at 1:00 p.m. with registered nurse (RN)-B, confirmed that no documentation of restorative nursing had been done since 8/23/14 and that there were gaps in the August, 2014 documentation. RN-B stated that the stretch for the right leg should have been done and that the new recommendation should have been put into place. The director of nursing (DON) on 9/4/14 at 1:58	F 282		

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F 282	Continued From page 19 p.m. stated that she wasn't aware of the recommendation from therapy. The DON indicated that one of the registered nurses yesterday noted that there was a recommendation from therapy for the sit and glide. The DON stated that usually therapy will give recommendations and then the recommendations are given to the restorative nurses and put on the restorative care plan. The DON on 9/4/14 at 4:50 p.m., stated they had no policy for the restorative program when requested.	F 282		
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 document review, the facility failed to provide necessary grooming for 2 of 3 residents (R5, R9) whom were dependent on staff for activities of daily living (ADL), whom were reviewed for ADL skills. Findings include: R5's quarterly Minimum Data Set (MDS), dated 7/2/2014, identified moderate cognitive impairment, and that R5 needed extensive assistance with personal hygiene and dressing. The care plan, updated 4/21/2014, indicated R5 needed the assist of one to clip her nails on bath	F 312	Caledonia Care & Rehab does ensure for the 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. 1. Facial hair has been removed from R 5. R9 was actively dying, receiving Comfort Cares as well as Hospice Services. R9 had pushed staff's hand away when attempting to provide oral care and had removed oxygen tubing from face, indicating it was not comfortable to have things on/by face. R9 expired on 9.4.14 during the survey.	

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F 312	Continued From page 20 days, and to make sure R5's clothing and appearance is neat and comfortable in appearance. During observation on 9/2/2014 at 3:45 p.m., R5 was seated in a recliner in her room, looking at a newspaper. R5 had numerous, unshaven facial hairs on her chin, approximately one-half inch in length. During an interview on 9/3/2014 at 11:15 a.m., R5 stated she had a bath earlier in the morning, but said her fingernails "were not trimmed." R5 then took off her socks, exposing her feet. R5 then said, "Look at my toenails, they are ridiculous, and haven't been cut in I don't know how long." The surveyor asked R5 if she groomed facial hair by herself, and R5 responded, "No, and I don't like how it looks." R5 said the "girls" usually trim her chin hair, and they also cut nails on her bath day. R5 stated, "That didn't get done; none of that got done." In an interview on 9/3/2014 at 2:36 p.m. licensed practical nurse (LPN)-A verified she bathed R5 earlier in the day, but that she did not yet clipped R5's finger or toenails, nor groomed her chin hair. LPN-A stated that the shaving of facial hair and cutting of nails were "routinely completed during resident baths." During observation of morning cares on 9/4/2014 at 9:19 a.m., R5's facial hair remained uncut, and R5's fingernails and toenails also had not been groomed. During an interview on 9/4/2014 at 9:42 a.m., nursing assistant (NA)-B verified R5 had facial hair on her chin, that her toe nails and fingernails	F 312	2. Personal shavers were purchased for the female residents who wish to have facial hair removed. The shavers are stored in their medication drawers for easy access. 3. Personal shavers will be available for all female residents who require the removal of facial hair in our supply room. Hair removal will be care planned and monitored for removal if so desired. Education for all staff will be provided at an inservice on October 16 and October 17. 4. Audits will be performed by DON/designee for removal of facial hair on all female residents. They will be done weekly for one month, monthly for three months, and then quarterly for one year. They will be shared with our Quality Assurance & Assessment Team. 5. Completion date: ~~October 19, 2014.~~	10-14-14 GPN

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F 312	Continued From page 21 were all in need of trimming. NA-B stated, "That should have been done along with R5's weekly bathing." During an interview on 9/4/2014 at 3:36 p.m., LPN-B stated, "I would expect," when a resident is given a bath, "hair and nail care be completed," and that "facial grooming" for the resident also be completed. In an interview on 9/4/2014 at 4:30 p.m., the director of nursing (DON) stated that each resident needed to be asked what specific grooming he or she wanted, and then provide assistance as needed. If a resident is unable to do for him or herself, the DON said, "I would expect we groom that resident." A facility policy regarding resident grooming was requested, but none was provided. R9's significant change in status Minimum Data Set (MDS), dated 7/30/14, indicated R9 was cognitively intact, displayed no behavioral symptoms, and required supervision of staff to ensure personal hygiene care was completed. R9's care plan, dated 7/29/14, indicated R9 required dependent assist from nursing staff to complete grooming. R9 was observed on 9/2/14 at 5:03 p.m. to be lying in bed. R9 had black and white facial hair on her upper lip. During subsequent observations on 9/3/14, at 8:23 a.m. and 1:55 p.m., R9 remain in bed with facial hair on her upper lip. During interview on 9/4/14, at 7:30 a.m., nursing assistant (NA)-D stated R9 normally did not have facial hair. NA-D stated facial hair should be	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245499	A. BUILDING _____ B. WING _____	09/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALEDONIA CARE AND REHABILITATION CENTER	425 NORTH BADGER STREET CALEDONIA, MN 55921

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F 312	Continued From page 22 removed with routine care unless there is a preference to have it. NA-D stated R9 did not have a personal preference for facial hair to her knowledge, and it should have been removed when staff completed personal hygiene cares. When interviewed on 9/4/14, at 7:56 a.m., licensed practical nurse (LPN)-B stated R9 was completely dependent on staff for personal hygiene and grooming. LPN-B further stated R9's facial hair should have been removed. During interview on 9/4/14, at 9:16 a.m., registered nurse (RN)-B stated R9 was completely dependent on staff to have grooming and personal hygiene completed. RN-B stated R9 would have an identified preference in the care plan if she desired to have facial hair; however acknowledged R9 had no such documentation in her care plan. RN-B further stated R9's facial hair should have been removed. When interviewed on 9/4/14, at 1:58 p.m., the director of nursing (DON) stated women should be shaved promptly if facial hair is observed unless they have an identified preference to have it. The DON further stated she didn't feel R9's unshaved facial hair was an issue of concern. A facility policy on grooming and personal hygiene was requested, but none was provided.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores	F 314		

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F 314	Continued From page 23 does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide care and services to promote healing of a current stage three pressure ulcer for 1 of 3 residents (R3) reviewed with a pressure ulcer. Findings include: R3 had not received repositioning to relieve pressure on the coccyx area with the stage three pressure ulcer for more than 2 hours and 34 minutes even though R3 was assessed to need repositioning every 1.5 hours to promote healing and prevent other ulcers from developing. R3 had diagnoses which included Multiple sclerosis, and Diabetes Type 2 adult onset found on the face sheet. The quarterly Minimum Data Set (MDS) dated 8/6/14; identified R3 had a stage 3 pressure ulcer (full thickness tissue loss, exposing the subcutaneous tissue) and, was incontinent of bowel and bladder. R3's care plan revised 6/24/14, identified R3 had "impaired skin integrity," and had a repositioning schedule of 1.5 hours when in bed and a check and change of incontinent liners every 2 hours.	F 314	F 314 Caledonia Care & Rehab does provide an environment where a resident having a pressure sore receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. 1. R3 pressure sore area was reviewed by our wound nurse on 9.15.14 and again on 10.1.14. Treatment has been changed to a thicker hydrocolloid product to prevent shearing when moving her in the lift sling to seated position in Broda chair. 2. A review of all residents indicated there were no other residents with pressure sore. Turning and repositioning programs are in place for residents and care planned. 3. Education will be provided to staff reiterating need for scheduled repositioning and incontinence care in order	

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F 314	Continued From page 24 Review of the weekly skin assessment for past three month (June, July, August and September 1, 2014), identified various interventions which included a turning and repositioning schedule. During an interview on 9/4/14 at 7:07 a.m. nursing assistant (NA)-K confirmed nursing assistants logged the time residents were provided cares and used the computer to track the next time care was to be provided. NA-K confirmed R3 was scheduled to receive cares which includes toileting and/or repositioning at 7:53 a.m. During observations on 9/4/14, from 7:06 a.m. to 8:49 a.m. the following was noted: 7:06 a.m. R3 was in bed positioned on her back with a pillow under the right side of her body. 8:25 a.m. R3 remained on her back with the pillow in the same position. 8:29 a.m. R3 remained in same position. 8:49 a.m. R3 remained in the same position. 8:49 a.m. continuous observation of R3 began. R3 remained in the same position on her back with the pillow under her right side, with no staff entering the room until 9:40 a.m. when nursing assistant (NA)-H entered the room to provide morning cares. R3's incontinent liner was saturated with urine and, a 2 inch square dressing was in place on the coccyx which was soiled on one edge with sanguineous (blood) drainage. R3 had not received incontinent care nor been repositioned for 2 hours and 34 minutes plus the time before observations started at 7:06 a.m. During an observation on 9/3/14, at 1:40 p.m. licensed practical nurses (LPN)-B, along with NA-H performed a dressing change to the ulcer.	F 314	to prevent the development of pressure sores. A post test will be completed after the training. 4. Audits will be completed by DON/Designee regarding turning and repositioning procedures and incontinent care weekly for one month, monthly for three months, and quarterly for one year. The results will be shared with the Quality Assurance & Assessment Team. 5. Completion date: ~~October 19, 2014.~~ error	10-14-14 BPN

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F 314	Continued From page 25 The ulcer was circular, with a diameter of 2 centimeters; the tissue was " beefy " red in color with a pink scarred area around the perimeter. During an interview on 9/3/14, at 10:07 a.m. NA-H confirmed staff had not checked, changed or repositioned R3 this morning, and this was a typical morning for R3. NA-H stated, "The 6 o'clock person [NA] does rounds in the morning" and confirmed 9:40 a.m. was the first time NA-H had entered R3's room. During an interview on 9/3/14 at 1:40 p.m. LPN-B stated staff is expected to check and change incontinent products and reposition R3 when in bed every 2 hours (However, the care plan for R3 read 1.5 hours for repositioning.) During an interview on 9/4/14, at 2:23 p.m. registered nurse (RN)-B, stated staff is expected to follow care plan to reposition and check and change residents. During an interview on 9/4/14 at 3:53 p.m. the director of nursing (DON) confirmed staff are expected to follow the care plan to check, change and reposition residents. The requested facility policy for pressure ulcer cares was not provided.	F 314		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase	F 318		

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Rochester

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F 318	Continued From page 26 range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide range of motion (ROM) services as recommended by physical therapy for 3 of 3 residents (R3, R7, R12) reviewed for range of motion. Findings include: R3 ' s quarterly Minimum Data Set (MDS) dated 8/6/14; identified R3's diagnoses included multiple sclerosis, had moderate impaired cognition, impaired functional limitation in range of motion to both sides of the upper and lower body, and had total dependence on staff for all areas of daily living (ADL). R3's care plan revised 7/11/14, identified R3 had impaired physical mobility, and had a restorative program that included, passive range of motion exercises including arm extensions, wrist flexion and extension, heel cord stretches, hamstring stretches, and knee bends for 12 to 15 repetitions with each exercise for a total of 15 minutes daily. During an observation on 9/4/1214, at 9:40 a.m. R3 was resting in bed with a pressure pad call light placed on her left shoulder. No ROM was noted to be done. Review of the ROM charting lacked any documentation that services were performed in the past 6 days.	F 318	Caledonia Care & Rehab does provide a resident with a limited range of motion appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. 1. R12, R3, and R7 charting was reviewed on 10.1.14 regarding ROM. Rehab aides received a note as well as conversation held with MDS Coordinator to assure that these individuals receive ROM every day and be documented. 2. A review of all residents was completed and a plan was developed on how to assure that all residents assessed for ROM needs were provided it. 3. Education will be provided on ROM process via a DVD developed by our therapy providers. The importance of completion of ROM exercises to maintain abilities of residents will be provided to staff.	

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F 318	Continued From page 27 During an interview on 9/3/14, at 10:07 a.m. nursing assistant (NA)H confirmed she had not performed PROM exercises for R3 and, stated NA's do not do exercises or range of motion for the residents, "a rehab (rehabilitation) aid does them." R7 ' s quarterly MDS dated 6/4/14, identified R7 had diagnoses which included post cardio vascular attack (CVA) with left sided hemiparesis, had moderate cognitive impairment, functional limitation in range of motion with impairment on one side of the body, upper and lower, and required extensive assistance with activities of daily living. R7 ' s care plan revised 6/17/14, identified R7 had a restorative program of ROM to arms and legs daily. During observation on 9/4/14, at 9:25 a.m. R7 was seated in a wheel chair with her left foot on a foot peddle, and left hand laying flaccid (Lacking firmness, resilience, or muscle tone) on her left thigh near the wheel chair arm rest. R7 ' s fingers were wrapped in a fist with the thumb inside the 4 fingers. During an interview on 9/4/14, at 4:15 p.m. R7 confirmed no exercise or ROM services were completed for her arm or legs today. Review of the ROM charting lacked documentation that services had been completed for the past 6 days. During an interview on 9/4/13, 8:36 a.m. NA-E stated "we do not have enough staff," since some staff returned to school and others have quit. " NA-E confirmed 2 rehabilitative (rehab) aids perform all exercise and ROM services. NA-E	F 318	4. Audits will be performed by DON/Designee to assure that ROM is performed on those residents assessed for the need. Audits will be completed monthly for three months, quarterly for one year. 5. Completion date: ~~October 19, 2014.~~ 10/24/07	10-24-14 GPN

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F 318	Continued From page 28 explained due to the shortage of staff, the rehab aids are moved into the nursing assistant position and no one performed the ROM services. During an interview on 9/4/14, 2:21 p.m. registered nurse RN-B confirmed ROM services for R3 and R7 were scheduled to be completed daily, and staff charted the services completed in the computer charting. RN stated when a rehab aid is needed to work as a nursing assistant "we don't have someone to cover that now," and the residents do not receive ROM services. During an interview on 9/4/14 at 3:53 p.m. the director of nursing (DON) confirmed the resident care plan for daily range of motion should be followed by staff. The DON stated if the rehab aid was pulled from the floor all staff should work together to complete all cares for residents include the daily ROM services. A requested facility policy for rehabilitative services was not provided. R12's physician visit form dated 7/22/14 indicated that R12's diagnoses included cerebrovascular accident (CVA), depression, hemiplegia, diabetes mellitus and coronary artery disease. The quarterly Minimum Data Set (MDS) dated 8/13/14 indicated that R12 had a score of 12 on the brief interview for mental status (BIMS) indicating R12 ' s cognition was moderately impaired. It also noted that R12 was extensive assistance of two staff with bed mobility, transfer, dressing toileting, personal hygiene, and was independent with eating after set up. The annual MDS dated 2/19/14 indicated that R12 had impairment on one side for upper and lower extremities. According to the certified nursing assistant's assignment card dated	F 318		

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F 318	Continued From page 29 7/11/14 for restorative, R12 had a CVA with right sided hemiplegia. According to the discharge physical therapy note dated 8/28/14 restorative nursing was directed to do the following for R12: Sit and glide (L) Lower extremity for 15 minutes. Continue with brace to stretch right knee and right knee extension passive range of motion exercise. R12's restorative plan of care dated 7/11/14 indicated that R12 had limited range of motion to the right leg related to her CVA. Instructions included assisting resident to apply knee brace to right side for up to 1 hour daily to aide in stretching of the knee and hamstring. The total time brace was left on was to be documented. The level of extension in degrees R12 was able to perform was to be documented. Documentation of the restorative nursing charting for R12 for August, 2014 and September, 2014 was reviewed. There was no documentation of restorative nursing from 8/1/14 through 8/7/14. There was no documentation of restorative nursing being completed from 8/23/14 to 9/4/14. An interview on 9/3/14 at 1:19 p.m. with the physical therapy aide, (PTA) she indicated that R12 was discharged from therapy on 8/28/14. The PTA indicated that R12 was to be on a sit and glide restorative program 15 minutes each day. During an interview with registered nurse (RN)-B, she confirmed that no documentation of restorative nursing had been done since 8/23/14 and that there were gaps in the August, 2014 documentation. RN-B stated that the stretch for the right leg should have been done and that the new recommendation should have been put into place. The director of nursing (DON) on 9/4/14 at 1:58 p.m. stated that she wasn't aware of the	F 318		

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F 318	Continued From page 30 recommendation from therapy. The DON indicated that one of the registered nurses yesterday noted that there was a recommendation from therapy for the sit and glide. The DON stated that usually therapy will give recommendations and then the recommendations are given to the restorative nurses and put on the restorative care plan. The DON on 9/4/14 at 4:50 p.m., stated they had no policy for the restorative program.	F 318		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nutritional needs were reassessed and interventions were affective to stabilize weight for 1 of 3 residents (R35) who had steady weight loss since admission to the facility on May 21, 2014. Findings include: R35 was admitted on 5/21/14 according to the	F 325	Caledonia Care & Rehab does maintain acceptable parameters of nutritional status, such as body weight and protein levels; unless the resident's clinical condition demonstrates this is not possible. We also assure residents receive a therapeutic diet when a nutritional issue/challenge is present. 1. The dietician visited R35 on 9.9.2014 with previous visits on 6.3.14 and 8.26.14. On 8.26.14 resident commented on being use to the food spouse makes. A note was sent to dietician on 7.30.14 from nursing regarding decrease in weight and dietician did address in August. The dietician assessed R35 post survey on 9.9.14 with	

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F 325	Continued From page 31 face sheet and weighed 160 pounds and gradually lost weight over the past three months and on 7/31/14 weight was 136 pounds. However, a Nutritional reassessment had not been completed to prevent further weight loss. The admission minimum data set (MDS) dated 5/28/14 indicated that R35's brief interview for mental status (BIMS) was 10, indicating moderately impaired cognition and that R35 was independent in eating after set up. The physician admission note dated 5/30/14 indicated that R35's diagnoses included: ischemic dilated cardiomyopathy with ejection fraction in 20%, chronic kidney disease, stage IV, hypertension, hypothyroidism, chronic obstructive pulmonary edema and gastro esophageal reflux disease. R35's care plan indicated that dietary was to provide the ordered diet, no added salt (NAS)/small portions. Encourage fluids with and between meals as well as snacks as R35 did not eat 100% of lunch and supper meal. R35 had a good appetite for breakfast and enjoyed the breakfast meal. Registered Dietician to review status quarterly. R35's weights in pounds were as followed: 9/3/14 was 142.3 8/27/14 was 139.4 8/20/14 was 142.2 8/14/14 was 139 8/7/14 was 140.4 7/31/14 was 136 7/24/14 was 134.2 7/17/14 was 144.1	F 325	recommendations followed through on by the following input: On 9.11.14 diet was changed from NAS to General and was ordered a supplement. On 9.22.14 an order was received for remeron to be utilized as an appetite enhancement and the VA will deliver sometime between 9.29.14 and 10.2.14. R35s weight has increased by 2.1 pounds. 2. A review of all residents was completed to determine if anyone showed weight fluctuations in need of review by the dietician. A review of dietician visits was completed, noting residents that had not been seen in the last two months with request for dietician to review and see as appropriate. Weights not deemed appropriate by reviewer were addressed with direct care staff to reweigh.	

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F 325	Continued From page 32 7/10/14 was 142 7/3/14 was 145.3 6/26/14 was 148.2 6/19/14 was 156.1 6/5/14 was 160.7 5/29/14 was 159.9 5/22/14 was 159.6 5/21/14 was 160.0 The nutritional assessment dated 6/3/14 indicated that R35's diet order was NAS, small portions. Pertinent medications were laxative, multivitamin, diuretic. R35's usual weight was 160 pounds. Weight goal was to maintain. Resident is receiving small portions at meals at this time. Meal intake is between 75-100% at breakfast. Lunch and supper intakes are between 25-100%, averaging 64 and 62% respectfully. Intervention: Continue with current diet order and monitor weights/intakes. Evaluation/Goals: 1) Maintain upper body weight (UBW) of 160-162 pounds. 2) Increase meal intake to 75% of food a majority of meals, and 3) show no signs or symptoms of dehydration. The RD quarterly note on 8/26/14 indicated that there had been a significant weight decline of 11.3% in the past 90 days. Resident is receiving a diuretic which may contribute to weight loss related to fluid. Diet is NAS and is receiving small portions at meals at this time. Meal intake is between 75-100% at breakfast. Lunch and supper intakes are between 25-100% averaging 53% and 68% respectfully. R35 stated that he was used to the food that his wife made. Intervention: Continue with current diet order. Nutrition staff will ask resident if he wants the entrée on the menu or a substitute such as hot turkey or ham sandwich. Will provide mashed	F 325	3. A review of our Weight Policy & Guidelines was performed with revision where appropriate. The dietary manager and nursing will collaborate to assure weights are monitored and declines are referred to registered dietician upon discovery. A folder has been established for all concerns to be placed for the dietary manager to relay to the registered dietician. 4. Audits will be completed by nursing/dietary to determine if any resident is at risk for weight loss. Audits will be done weekly for one month, monthly for three months and then quarterly. Audits will be shared with Quality Assurance & Assessment Team on a quarterly basis. 5. Completion date: ~~October 19, 2014~~. error	10-14-14 GPM

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	245499	A. BUILDING _____ B. WING _____	09/04/2014

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F 325	Continued From page 33 potatoes at lunch each day. Evaluation/Goals: 1) Gain 1-2 pounds per week. 2) Increase meal intake to 75% of food at majority of meals. During an interview with R35 on 9/3/14 at 12:23 p.m., R35 stated that his appetite was " So - So. " R35 stated that many foods at the facility are different than what he was used to eating. Breakfast is the best meal. R35 indicated he liked the cereal and a couple slices of bacon. R35 wished he could have toast and butter. On 9/3/14 at 11:30 a.m. R35 was noted to have been served ½ egg salad sandwich, mixed fruit cup, carrots, crackers, chicken tortilla soup, and coffee. R35 was eating himself. R35 told surveyor that the soup was too bland tasting and had no seasoning, so R35 was adding salt. During the meal the nursing assistant (NA)-Z asked R35 if he liked the meal, and R35 stated that no he didn't and that it was too bland. The NA-Z asked R35 if he wanted anything else and he said no. The NA-Z stated she would forward his complaint. R35 consumed; coffee, crackers, a few bites of carrots, and the soup. R35 did not eat the egg salad sandwich. The certified dietary manager, (CDM) during an interview on 9/3/14 at 3:57 p.m. stated that the facility will look at a resident's electronic charting to see if there has been a weight loss. Sometimes if they noticed that the resident is not eating well they will check. When asked if the registered dietician (RD) was aware of the weight loss that R35 started having in June, 2014, the CDM stated he would look for some documentation. When asked if he had notified the RD regarding R35's weight loss and he stated no.	F 325		

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F 353	Continued From page 35 provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide adequate nursing staff to meet the ongoing assessed needs and services for all residents in the facility as identified for 4 of 20 residents (R59, R43, R53, R50) who were reviewed according to the quality indicator survey (QIS) computer generated process. This had the potential to affect all residents who needed assistance of staff to meet their activities of daily living but not all 49 residents in the facility. Findings Include: LACK OF TIMELY CARES AND SERVICES	F 353	Caledonia Care & Rehab does provide staffing to meet the needs and services of the residents within our care. 1. Caledonia Care & Rehab had in the early summer, recognized staffing would be a concern come fall. In June, we established a recruitment policy and bonus. We are providing premium pay for hours picked up above regularly scheduled hours. We invited students from neighboring colleges to intern and train here. This provided some interest. In August, I received the okay to increase our wages. We continued with our birthday recognition and staff recognition for "catching someone going above and beyond" on a quarterly and yearly basis. In August we continued with our ads in	

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OCT 3 2014
MN Dept of Health Rochester

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F 353	Continued From page 36 REPORTED BY AFFECTED RESIDENTS: R59 was interviewed on 9/2/14, at 5:49 p.m.; R59 stated the staff was working "shorthanded." R59 further stated he had to wait for nearly 30 minutes to get his portable oxygen tank switched because staff didn't have time to help him and this was upsetting to him. R59's family member (FM)-A who was present during the interview, verified the amount of time, it took for staff to help R59 with his oxygen tank. R59's significant change in status Minimum Data Set (MDS), dated 6/18/14, indicated R59 had intact cognition. R43 was interviewed on 9/2/14, at 3:21 p.m.; R43 stated the staff worked shorthanded frequently. R43 stated the evening time is worst, as only 2 people (staff) are present to get residents ready for bed. Further, R43 stated she has had incontinence episodes in the past because of having to wait so long for help to the bathroom. R53 was interviewed on 9/4/14, at 9:49 a.m.; R53 stated he has suffered incontinent episodes because he does not receive timely assistance to the toilet. R53 stated he has taken himself to the bathroom before (against recommendations) because of the fear of a long wait time for staff help. R53 further stated he has called the facility before from his personal phone to ask for help because no staff responds to his call light. R53's admission Minimum Data Set (MDS), dated 5/23/14, indicated R53 had intact cognition, and required extensive assistance from staff for toileting and dressing. R50's brief interview for mental status (BIMS) was 15 according to the quarterly MDS dated 6/4/14, which indicated R50 was cognitively	F 353	local and surrounding towns' papers, craigslist, placed posters in the local school, and added a sign-on bonus. In September, we had staff appreciation. When it was clear we were not with optimum staffing, the scheduler, an LPN, and two direct care staff met to establish a workable schedule to care for the residents. Staffing is adequate and meets the MN guidelines when everyone is in attendance. During the survey, two out of the three days someone called in for the day shift. Licensed staff assisted as was able but were limited due to the survey process. We provide our own nursing assistant classes to aid in recruitment as well. Since the survey process we have maintained all of the above and added radio ads to the recruitment process.	

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F 353	Continued From page 37 intact. During an interview on 9/2/14 at 3:48 p.m., R50 stated she did not feel there was enough staff to take care of her needs. R50 stated that sometimes she has to wait a half an hour or more when she puts her call light on. R50 indicated the worst times for not getting help timely was early morning and at night when residents were being put to bed. LACK OF SERVICES AND CARE BEING COMPLETED AS REPORTED BY STAFF: During interview on 9/3/14, at 2:46 p.m., nursing assistant (NA)-F stated the facility had recently made staffing changes. NA-F further stated it was hard getting all assigned resident tasks completed and they (NA's) could use more help. When interviewed on 9/3/14, at 4:26 p.m., NA-G stated the number of staff on the South Wing was recently dropped down to three NA's from four NA's. NA-G stated the remainder of the units should have two NAs and one trained medication aide (TMA). NA-G stated they (NAs) needed more help. NA-G further stated s/he has observed call lights be on for long periods of time because they cannot get to them right away because of the work load. Further, NA-G stated residents sometimes do not get their range of motion, walking (on the night shift), and grooming completed because of the lack of staff to do these tasks. During interview on 9/4/14, at 8:45 a.m., NA-H stated facility cleaning is not done as it should (NA's completed the housekeeping duties such as cleaning resident rooms as well as assigned to resident cares), nor are call lights answered promptly because of the low staffing. NA-H	F 353	Our website has been up and running with information regarding staff openings. 2. We will continue to promote recruitment activities. Staffing will be dealt with on a day-by-day basis. Licensed staff is assisting with schedules. When there are openings for admissions, we will determine what level of care is needed, and if they would be an appropriate admission at the time. 3. Caledonia Care & Rehab recognizes staffing issues will be an on-going concern. Administrative staff is lobbying to encourage increasing reimbursement to facilities to better allow us to pay our staff what they deserve. We are promoting through colleges	

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

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F 353	Continued From page 38 stated several residents have been upset and complained about the time it takes for their call light to be answered before they get help. NA-H further stated resident care, particularly grooming, had been suffering as a result of the staffing. During a subsequent interview with NA-H, on 9/4/14 at 3:32 p.m., NA-H stated she had been unable to complete timely repositioning for R3 because she was too busy as she continued to say, "Had to get other people up and alarms were going off." When interviewed on 9/4/14, at 1:48 p.m., NA-B stated the staff (NAs) struggles to get the assigned work load completed. NA-B stated getting shaving and grooming completed everyday was difficult, and the rehabilitation aide often is pulled from their duties to provide direct care for the residents because of low staffing. Further, NA-B stated, "I do feel staffing needs to be addressed." During interview on 9/4/14, at 2:21 p.m., registered nurse (RN)-B stated they noticed that no staff was consistently completing range of motion for the residents when the rehabilitation aide is pulled from their duties. RN-B said, "...we don't have someone to cover that [ROM services] now." LACK OF TIMELY CALL LIGHT RESPONSE BY STAFF AS SHOWN BY CALL LIGHT AUDITS: The facility provided call light reports for all units during the time period of August 27, 2014 to September 3, 2014, however only included the morning (12:02 a.m. through 8:16 a.m.) for August 31, 2014, and did not include August 30,	F 353	the care of the geriatric population by having clinicals in our setting. We will continue our work on the household method with Health Support Specialist to help us become a facility where individuals wish to work. Ideas will be presented to staff for improvement in their working environment and sharing of duties through the promotion of change to homelike setting as outlined in Aging Services and Stratis Health Initiatives.	

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F 353	Continued From page 39 2014. The reports indicated the call lights were triggered 1668 times during that period, and of that 197 times they exceeded 10 minutes (range 10 minutes to 59 minutes 15 seconds in time) or 11.8% of the time, residents had to wait over 10 minutes to receive help and assistance. When interviewed on 9/4/14, at 4:24 p.m., the administrator stated several staff had recently left the facility to go back to school or participate in sports, and she was aware staffing was, "not at the optimum." Further, the administrator stated call lights should be answered within 6-9 minutes, and despite being aware of staffing concerns, no written plan of action was developed by the facility Quality Assurance committee to address the concern. A facility policy on staffing and procedures was requested, but was not provided. ADDITIONAL STAFFING CONCERNS IDENTIFIED IN THE FOLLOWING TAGS THAT ADDRESS RESIDENT CARES AND SERVICES THAT WERE NOT PROVIDED AS RESIDENT SPECIFIC NEEDS WERE ASSESSED: See F241: Based on observation, interview and document review, the facility failed to enhance the resident ' s self-worth and self-esteem by providing and environment that promotes dignity for 2 of 2 residents (R28 and R53) who did not receive services that promoted dignity. R28 lacked clothing adjustments to cover abdomen. R53 lacked timely toileting needs and soiled self with urine while waiting for help. See F242: Based on interview, observation and document review the facility failed to follow	F 353	4. Audits of staffing hours will be completed daily with additional help sought on days that are not optimum. Licensed staff will assist as needed. The hiring and orientation process will continued. 5. Completion date: ~~October 19, 2014.~~ Error 10-14-14 GPM	

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F 353	Continued From page 40 identified family preferences related to care for 1 of 1 resident (R28) reviewed for choices. R28 ' s family wanted R28 to be up for meals at specific times and this was not accommodated. See F253: Based on observation, interview, and document review, the facility failed to maintain a clean room for 1 of 1 residents (R28) identified by family has not having a clean room. R28 ' s room had a thick layer of dust and debris on the floor. See F282: Based on observation, interview, and document review, the facility failed to implement resident care plan interventions to promote healing and/or prevent increase of a current pressure ulcer for 1 of 3 residents (R3) reviewed with a pressure ulcer, in addition the facility failed to implement the care plan range of motion services for 3 of 3 residents (R3, R7, R12) reviewed who received these services. R3 was not repositioned for more than 2 hours and 34 minutes even though she had a stage three pressure ulcer on the coccyx. R3, R7, R12 did not receive consistent range of motion (ROM) services as staff were often pulled from nursing rehabilitative services to do direct care for residents. See F312: Based on observation, interview, and document review, the facility failed to provide necessary grooming for 2 of 3 residents (R5, R9) whom were dependent on staff for activities of daily living (ADL), whom were reviewed for ADL services. See F314: Based on observation, interview and document review, the facility failed to provide care to promote healing of a current pressure ulcer for 1 of 3 residents (R3) reviewed with a pressure	F 353		

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F 353	Continued From page 41 ulcer. As with F282 R3 had not received repositioning services assessed to be done every 1.5 hours and R3 was allowed to go 2 hours and 34 minutes before being repositioned and pressure relieved on an open stage three pressure ulcer. See F318: Based on observation, interview, and document review, the facility failed to provide range of motion as recommended by physical therapy (PT) for 3 of 3 residents (R3, R7, R12) reviewed for range of motion. As stated in F282 these three residents were not provided ROM services due to the rehabilitative nursing assistant was pulled to help do direct resident cares and then the ROM services were not completed.	F 353		
F 431 SS=E	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	F 431	Caledonia Care & Rehab does ensure emergency medications are not expired and available for resident use. 1. Expired medication was removed from E-Kit on 9.4.14 and locked in narcotic box to be destroyed by pharmacy consultant. 2. All other E-kit medications were checked for expiration dates. Pharmacy was notified on 9.5.14 of expired medication in E-Kit for replacement.	

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F 431	Continued From page 42 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure emergency medications were not expired and available for resident use for 1 of 1 emergency kit. This had the potential to any resident in need of these medications but it may not be all 49 residents residing in the facility. During routine review of the medication storage 9/3/14, at 2:57 p.m. with registered nurse (RN)-C, the emergency kit was checked for medication storage. There were two vials of Lorazepam (to treat anxiety) were observed to have been expired. The printed expiration date was 4/14, having been expired for 5 months. During an interview on 9/3/14, at 3:05 p.m. RN-C confirmed the expired vials of Lorazepam, and that the pharmacist was responsible for checking the emergency kit. During an interview on 9/4/14, at 3:53 p.m. the	F 431	3. Pharmacy Consultant will check the E-Kit on a monthly basis for expired medications while doing his review. He will document and inform nursing of any medications that are nearing the date of expiration for removal and need to reorder. 4. Audits will be completed by DON/designee on a monthly basis for three months and then quarterly for one year. These audits will be shared with the Quality Assurance & Assessment Committee on a quarterly basis. 5. Completion date is ~~October 19, 2014~~. error	10-14-14 GPN

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F 431	Continued From page 43 director of nursing (DON) confirmed the pharmacist "switched out" the emergency medications, however, the DON believed nursing staff had been reviewing expiration dates. The DON confirmed the expectation had been that emergency medications would not be out dated. During an interview via phone on 9/5/14, at 1:40 p.m. the consulting pharmacist-A stated he did not review emergency medications that would be the responsibility of the pharmacy that provided the medications. The requested facility policy concerning emergency kits and medication storage was not provided.	F 431		
F 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain a freezer in good working order for 1 of 4 freezers observed during the initial kitchen tour. This had the potential to affect all 49 residents living in the facility who receive food from the kitchen. Findings Include: During the initial kitchen tour on 9/2/14 at 1:12 p.m., a white upright freezer was observed to have a heavy buildup of frost and ice on the three internal shelves and the freezer ceiling. The freezer contained one box of sausage links, one box of bacon, one box of French toast, one box of pancakes, one box of frozen berries, two plastic	F 456	Caledonia Care & Rehab does maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. 1. The freezer was cleaned and made free of ice on September 5, 2014. 2. The freezer was added to the monthly check off sheet that the kitchen has for all of the freezers.	

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F 456	Continued From page 44 containers of strawberries, one bag of cinnamon roll dough, and 1 box of eggs. The dietary manager (DM) verified all three shelves and the ceiling had an inch or more of thick frost and ice buildup. The DM stated the freezer was to be cleaned out every six months and stated it was due to be cleaned. The DM stated he was the delegated staff person responsible for cleaning the freezer. During an interview on 9/3/14 at 11:24 p.m. the DM stated the white upright freezer was not on a schedule to be cleaned and was not on the deep cleaning list. The DM stated he was unsure the last time the freezer had been cleaned as there was no record. Facility policies were requested for ongoing maintenance of the freezers and none was provided.	F 456	3. Education will be provided by the dietician and dietary manager so that dietary staff is aware of the need for monitoring and assuring that these areas is maintained ice free. 4. Audits will be added to the dietary manager/dietician's checks to assure that all freezers are maintained ice free. The audits will be completed on a monthly basis times three months and then quarterly times a year. Audits will be shared with the Quality Assurance & Assessment Committee. 5. Completion date: ~~October 19, 2014.~~ 10/31/14	10-14-14 GPJ
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview the metal storage areas in the kitchen were not maintained in a state of good repair to promote a sanitary surface. This affected all 46 residents in the facility who ate foods provided from the utensils located on the metal storage areas. Findings include:	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245499	A. BUILDING _____ B. WING _____	09/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALEDONIA CARE AND REHABILITATION CENTER	425 NORTH BADGER STREET CALEDONIA, MN 55921

(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 465	Continued From page 45 During a kitchen tour on 9/3/14 at 3:02 p.m. the assistant dietary manager verified the metal storage areas where pans and salad containers were stored and the metal shelf underneath the food preparation station had peeling, rough, uneven chipped paint that created a surface that was unable to be cleaned and sanitized. During a kitchen tour on 9/3/14 at 3:07 p.m. the administrator verified the metal storage areas where pans and salad containers were stored and the metal shelf underneath the prep station had peeling, rough, uneven chipped paint that created an un-cleanable surface. The administrator stated the metal storage areas in the kitchen had been sandblasted and repainted in the past and stated the facility would have to look into options to have these areas repaired. Facility policies were requested for cleaning of freezers and maintaining storage areas in the kitchen with cleanable surfaces and none were provided.	F 465	Caledonia Care & Rehab does provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. 1. Stainless steel racks have been purchased to replace the cupboards. The cupboards will be painted and used for storage of paper products after the racks are installed. 2. All cupboards will be checked and determined if painting needs to be completed. Painting will be done on all items needing it. 3. Education will be completed by dietary manager/dietician so that staff is aware of the need to maintain a cleanable surface. They will be informed of the need to pass information along to dietary manager for needed repairs. 4. Audits will be completed monthly times three months by the dietary manager/designee then quarterly for a year. Information will be shared at the Quality Assurance & Assessment Committee Meeting on a quarterly basis. 5. Completion date: ~~October 19, 2014~~ 10-14-14 GPN	

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	245499	A. BUILDING 01 - THE LUTHERAN HOME CALEDONIA B. WING _____	09/08/2014

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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 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Caledonia Care and Rehab 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: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	POC ok JB 10-6-14 RECEIVED OCT - 3 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 10-19-14

EXIT: 9-4-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Marian Rauk	Administrator	10.2.14

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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	245499	A. BUILDING 01 - THE LUTHERAN HOME CALEDONIA B. WING _____	09/08/2014

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Caledonia Care and Rehab is a 1-story building. The building was constructed at 3 different times. The original building was constructed in 1961 and was determined to be of Type II(000)construction, with a full basement. In 1971, addition was constructed and was determined to be of Type II(000) construction, with no basement. In 1975, addition was constructed and was determined to be of Type II(000) construction, with no basement. Because the original building and the 2 additions are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is partially sprinklered as noted in K56 tag. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a	K 000		

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	245499	A. BUILDING 01 - THE LUTHERAN HOME CALEDONIA B. WING _____	09/08/2014

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K 000	Continued From page 2 census of 48 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 7 out 48 residents. Findings include: On facility tour between 8:40 AM and 12:40 PM on 09/08/2014, observation revealed, that the 1st floor activities storage room (over 50 sq ft) has no automatic door closer.	K 029	The conference room will be cleaned out by October 15, 2014. It was cleared of all items that made it a storage area. Completion date: October 15, 2014.	

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	245499	A. BUILDING 01 - THE LUTHERAN HOME CALEDONIA B. WING _____	09/08/2014

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K 029	Continued From page 3 This deficient practice was confirmed by the Facility Maintenance Director (RK) at the time of discovery.	K 029		
K 045 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview with staff, the facility failed to provide continuous illumination of exit access corridors in accordance with LSC Sections 19.2.8 and 7.8 . This deficient practice could affect 35 of the 48 residents, as well as an undeterminable number of staff and visitors, if an evacuation was hindered due to an unilluminated exit access corridor. Findings include: When I arrived at 0840 hours, both the south and east corridors were completely dark. On facility tour between 8:40 AM and 12:40 PM on 09/08/2014, an interview with the Facility Maintenance Director (RK) revealed all the exit access corridors have overhead lights controlled by circuit breakers. The staff would shut off two circuit breakers in each hallway so the resident south and east hallways would be in complete darkness. With these circuit breakers turned off,	K 045	K 45 Illumination of means of egress 1. LED Night lights were installed on wings to provide light for egress in the week of October 6-10, 2014. These lights will automatically turn on when overhead lights are turned off. 2. Maintenance will place these lights on their walk around sheets to monitor for burn out and replace as necessary. 3. Completion date: October 19, 2014	

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	245499	A. BUILDING 01 - THE LUTHERAN HOME CALEDONIA B. WING _____	09/08/2014

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K 045	Continued From page 4 the exit access corridors did not have the required level of continuous illumination as required by LSC Section 19.2.8 and 7.8.1. This deficient practice was confirmed by the Facility Maintenance Director (RK) at the time of discovery.	K 045	1. Fire drills will be conducted on a varied time schedule. Schedule was set up to provide assurance of timing with maintenance director. 2. Our new charting system has a maintenance division in it. Calendars can be set up to assure that a system is in place to assist the maintenance department in managing the fire drills so they are within the timeline variances required by the rules and regulations. 3. The administrator who has access to the charting system can monitor when the fire drill took place and if it was held at the appropriate time. 4. Audits will be completed on a monthly basis to assure that fire drills are carried out on the appropriate schedule by the administrator. 5. Completion date: October 19, 2014.	K50
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 48 residents. Findings include: On facility tour between 8:40 AM and 12:40 PM on 09/08/2014, the review of the fire drill documentation for the past 12 months (September 2013 to August 2014) revealed the	K 050		

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	245499	A. BUILDING 01 - THE LUTHERAN HOME CALEDONIA B. WING _____	09/08/2014

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K 050	Continued From page 5 drills for the following shift was completed but did not sufficiently vary the times that the drills were conducted: Night: 2226, 2345, 2238 and 2345 hours This deficient practice was confirmed by the Facility Maintenance Director (RK) at the time of discovery.	K 050		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide proper coverage of the fire sprinkler system as per 2000 NFPA 101 Chapter 19.3.5 and 9.7. The deficient practice could affect 5 out of 50 residents. FINDINGS INCLUDE: On facility tour between 8:40 AM and 12:40 PM	K 056	1. Sprinklers were installed in the lower level employees' rest rooms on September 12, 2014. 2. Sprinkler inspections are completed on a weekly, monthly and quarterly basis. Annual flow test and inspections are done by a certified company. If company has a suggestion for another install, maintenance will contact fire marshal and determine if needed and assure that they are installed.	

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K 056	Continued From page 6 on 09/08/2014, the review of the annual sprinkler inspection from Summit dated 4/17/2014, indicated that the employees men's and women's rest rooms in the lower level, do not have fire sprinkler protection. This was confirmed on building tour. This deficient practice was confirmed by the Facility Maintenance Director (RK) at the time of discovery.	K 056	3. Facility is currently fully sprinkled and does not require additional sprinkler heads. Maintenance will continue to inspect and assure that they are in working order at all times. Concerns will be shared with the Safety Committee. 4. Audits will be done on a monthly basis to assure that all the inspections are completed in a timely fashion. 5. Completion date: October 19, 2014.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6-4.1. The deficient practice could affect all 48 residents. Findings include: On facility tour between 8:40 AM and 12:40 PM on 09/08/2014, documentation review of the weekly inspection logs (September 2013 to	K 144		

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K 144	Continued From page 7 September 2014) for the diesel emergency generator revealed that the weekly operational inspections were missed for the weeks of 9/30 and 10/7/13. This deficient practice was confirmed by the Facility Maintenance Director (RK) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 144	K 144 Weekly emergency generator inspections will be completed on a weekly basis. A tool was developed to alert maintenance of the need for the inspection. Audits will be done on a monthly basis for three months to assure that the inspections were completed. Then they will be done on a quarterly basis to assure completion. Completion date: October 19,2014	

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	00073	A. BUILDING: _____ B. WING _____	09/04/2014

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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 September 2, 3, 4, 2014, 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 on the bottom of the first page in the line marked with "Laboratory Director's or Provider/Supplier Representative's signature." Make a copy of	2 000		

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2 000	Continued From page 1 these orders for your records and return the original to the address below: Minnesota Department of Health 18 Wood Lake Drive SE, Rochester, MN 55904 c/o Gary Nederhoff, Unit Supervisor	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement resident care plan interventions to promote healing and/or prevent increase of a current pressure ulcer for 1 of 3 residents (R3) reviewed with a pressure ulcer, in addition the facility failed to implement the care plan range of motion services for 3 of 3 residents (R3, R7, R12) reviewed who received these services. Findings include: LACK OF SERVICES AND CARE TO PROMOTE HEALING AND PREVENTION OF PRESSURE ULCER/S: R3 had not been repositioned for 2 hours and 34 minutes even though R3 had a stage three pressure ulcer on her coccyx and was assessed to need repositioning to relieve pressure on the	2 565		

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2 565	Continued From page 2 ulcer are every 1.5 hours. R3's care plan revised 6/24/14, identified R3 had "impaired skin integrity," and had a repositioning schedule of 1.5 hours when in bed and a check and change of incontinent liners every 2 hours. The quarterly Minimum Data Set (MDS) dated 8/6/14; identified R3 had a stage 3 pressure ulcer (full thickness tissue loss, exposing the subcutaneous tissue) and, was incontinent of bowel and bladder. During an interview on 9/4/14 at 7:07 a.m. nursing assistant (NA)-K confirmed nursing assistants logged the time residents were provided cares and used the computer to track the next time care was to be provided. NA-K confirmed R3 was scheduled to receive care of toileting and/or repositioning at 7:53 a.m. During observations on 9/4/14, at the following times: 7:06 a.m. R3 was in bed positioned on her back with a pillow under the right side of her body. 8:25 a.m. R3 remained on her back with the pillow in the same position. 8:29 a.m. R3 remained in same position. 8:49 a.m. R3 remained in the same position. 8:49 a.m. continuous observation of R3 began. R3 remained in the same position on her back with the pillow under her right side, with no staff entering the room until 9:40 a.m. when NA-H entered the room to provide morning cares. R3's incontinent liner was saturated with urine and a 2 inch square dressing was in place on the coccyx which was soiled on one edge with sanguineous (containing blood) drainage. During an observation on 9/3/14, at 1:40 p.m. licensed practical nurses (LPN)-B, along with	2 565		

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(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
2 565	Continued From page 3 NA-H performed a dressing change to the ulcer. The ulcer was circular, with a diameter of 2 centimeters; the tissue was " beefy " red in color with a pink scarred area around the perimeter. During an interview on 9/3/14, at 10:07 a.m. NA-H confirmed staff had not checked, changed or repositioned R3 this morning, and this was a typical morning for R3. NA- stated the "6 o'clock person does rounds in the morning" and confirmed at 9:40 a.m. was the first time NA- had entered R3's room to do cares. During an interview on 9/3/14 at 1:40 p.m. LPN-B stated staff is expected to check and change incontinent products and reposition R3 when in bed every 2 hours (however, the care plan says every 1.5 hours.) During an interview on 9/4/14, at 2:23 p.m. registered nurse (RN)-B, stated staff is expected to follow care plan to reposition and check and change residents. During an interview on 9/4/14 at 3:53 p.m. the director of nursing (DON) confirmed staff are expected to follow the care plan to check, change and reposition residents. LACK OF RANGE OF MOTION SERVICES AS DIRECTED BY THE CARE PLAN: R3's care plan revised 7/11/14, identified R3 had impaired physical mobility, and had a restorative program that included, passive range of motion exercises including arm extensions, wrist flexion and extension, heel cord stretches, hamstring stretches, and knee bends for 12 to 15 repetitions with each exercise for a total of 15 minutes daily. The quarterly minimum Data Set (MDS) dated 8/6/14, identified R3 had impaired functional	2 565		

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	00073	A. BUILDING: _____ B. WING _____	09/04/2014

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2 565	Continued From page 4 limitation in range of motion to both sides of the upper and lower body, had total dependence on staff for all areas of daily living (ADL). Review of the range of motion (ROM) charting lacked any documentation that services were performed in the past 6 days. During an interview on 9/3/14, at 10:07 a.m. NA-H confirmed she had not performed ROM exercises for R3 and, stated nursing assistants do not do exercises or range of motion for the residents, "a rehab (rehabilitation) aid does them." R7 ' s care plan revised 6/17/14 identified R7 had left sided hemiparesis, and a restorative program of ROM to arms and legs daily. The quarterly MDS dated 6/4/14, identified R7 had functional limitation in range of motion impairment on one side of the body, upper and lower and required extensive assistance with activities of daily living. During an interview on 9/4/14, at 4:15 p.m. R7 confirmed no exercise or ROM services were completed for her arm or legs today. Review of the ROM charting lacked documentation that services had been completed for the past 6 days. During an interview on 9/4/13, 8:36 a.m. NA-E stated, "We do not have enough staff," since some staff returned to school and others have quit. " NA-E confirmed 2 rehab aids perform all exercise and ROM services. NA-E explained due to the shortage of staff, the rehab aids are moved into the nursing assistant position and no one performed the ROM services.	2 565		

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2 565	Continued From page 5 During an interview on 9/4/14, 2:21 p.m. RN-B confirmed ROM services for R3 and R7 were scheduled to be completed daily. RN-B stated when a rehab aid is needed to work as a nursing assistant "we don't have someone to cover that now," in regards to rehab aid doing ROM for residents so it is not completed. During an interview on 9/4/14 at 3:53 p.m. the DON confirmed the resident care plan for daily range of motion should be followed by staff. The DON stated if the rehab aid was pulled from the floor all staff should work together to complete all cares for residents include the daily ROM services. A requested facility policy was not provided in regards to ROM services. R12 was not provided ROM services as directed on the comprehensive care plan. The physician visit dated 7/22/14 indicated that R12's diagnoses included cerebrovascular accident (CVA), depression, hemiplegia, diabetes mellitus and coronary artery disease. R12's restorative plan of care dated 7/11/14 indicated that R12 had limited range of motion to the right leg related to her CVA. Instructions included assisting resident to apply knee brace to right side for up to 1 hour daily to aide in stretching of the knee and hamstring. The total time brace was left on was to be documented. The level of extension in degrees R12 was able to perform was to be documented. Documentation of the restorative nursing charting for R12 for August, 2014 and September, 2014 was reviewed. There was no documentation of restorative nursing from 8/1/14 through 8/7/14. There was no documentation of restorative nursing being completed from 8/23/14 to 9/4/14.	2 565		

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2 565	Continued From page 6 An interview on 9/3/14 at 1:19 p.m. with the physical therapy aide, (PTA) indicated that R12 was discharged from therapy on 8/28/14 and given to nursing to complete exercises. The PTA indicated that R12 was to be on a sit and glide restorative program 15 minutes each day. Review of the discharge summary from physical therapy dated 8/29/14 read that physical therapy's last visit was 8/28/14. R12 would be set up on restorative with Sit-Glide and right knee extension passive range of motion exercise. During an interview on 9/4/14 at 1:00 p.m. with registered nurse (RN)-B, confirmed that no documentation of restorative nursing had been done since 8/23/14 and that there were gaps in the August, 2014 documentation. RN-B stated that the stretch for the right leg should have been done and that the new recommendation should have been put into place. The director of nursing (DON) on 9/4/14 at 1:58 p.m. stated that she wasn't aware of the recommendation from therapy. The DON indicated that one of the registered nurses yesterday noted that there was a recommendation from therapy for the sit and glide. The DON stated that usually therapy will give recommendations and then the recommendations are given to the restorative nurses and put on the restorative care plan. The DON on 9/4/14 at 4:50 p.m., stated they had no policy for the restorative program when requested. SUGGESTED METHOD OF CORRECTION: The director of nursing could provide education on the importance of following the care plan and then do follow up audits/observation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		

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2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide adequate nursing staff to meet the ongoing assessed needs and services for all residents in the facility as identified for 4 of 20 residents (R59, R43, R53, R50) who were reviewed according to the quality indicator survey (QIS) computer generated process. This had potential to affect all 49 residents in the facility. Findings Include: LACK OF TIMELY CARES AND SERVICES REPORTED BY AFFECTED RESIDENTS: R59 was interviewed on 9/2/14, at 5:49 p.m.; R59 stated the staff was working "shorthanded." R59 further stated he had to wait for nearly 30 minutes to get his portable oxygen tank switched because staff didn't have time to help him and this was upsetting to him. R59's family member (FM)-A who was present during the interview, verified the amount of time, it took for staff to help R59 with his oxygen tank. R59's significant change in	2 800		

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2 800	Continued From page 8 status Minimum Data Set (MDS), dated 6/18/14, indicated R59 had intact cognition. R43 was interviewed on 9/2/14, at 3:21 p.m.; R43 stated the staff worked shorthanded frequently. R43 stated the evening time is worst, as only 2 people (staff) are present to get residents ready for bed. Further, R43 stated she has had incontinence episodes in the past because of having to wait so long for help to the bathroom. R53 was interviewed on 9/4/14, at 9:49 a.m.; R53 stated he has suffered incontinent episodes because he does not receive timely assistance to the toilet. R53 stated he has taken himself to the bathroom before (against recommendations) because of the fear of a long wait time for staff help. R53 further stated he has called the facility before from his personal phone to ask for help because no staff responds to his call light. R53's admission Minimum Data Set (MDS), dated 5/23/14, indicated R53 had intact cognition, and required extensive assistance from staff for toileting and dressing. R50's brief interview for mental status (BIMS) was 15 according to the quarterly MDS dated 6/4/14, which indicated R50 was cognitively intact. During an interview on 9/2/14 at 3:48 p.m., R50 stated she did not feel there was enough staff to take care of her needs. R50 stated that sometimes she has to wait a half an hour or more when she puts her call light on. R50 indicated the worst times for not getting help timely was early morning and at night when residents were being put to bed. LACK OF SERVICES AND CARE BEING COMPLETED AS REPORTED BY STAFF:	2 800		

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2 800	Continued From page 9 During interview on 9/3/14, at 2:46 p.m., nursing assistant (NA)-F stated the facility had recently made staffing changes. NA-F further stated it was hard getting all assigned resident tasks completed and they (NA's) could use more help. When interviewed on 9/3/14, at 4:26 p.m., NA-G stated the number of staff on the South Wing was recently dropped down to three NA's from four NA's. NA-G stated the remainder of the units should have two NAs and one trained medication aide (TMA). NA-G stated they (NAs) needed more help. NA-G further stated s/he has observed call lights be on for long periods of time because they cannot get to them right away because of the work load. Further, NA-G stated residents sometimes do not get their range of motion, walking (on the night shift), and grooming completed because of the lack of staff to do these tasks. During interview on 9/4/14, at 8:45 a.m., NA-H stated facility cleaning is not done as it should (NA's completed the housekeeping duties such as cleaning resident rooms as well as assigned to resident cares), nor are call lights answered promptly because of the low staffing. NA-H stated several residents have been upset and complained about the time it takes for their call light to be answered before they get help. NA-H further stated resident care, particularly grooming, had been suffering as a result of the staffing. During a subsequent interview with NA-H, on 9/4/14 at 3:32 p.m., NA-H stated she had been unable to complete timely repositioning for R3 because she was too busy as she continued to say, "Had to get other people up and alarms were going off."	2 800		

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2 800	Continued From page 10 When interviewed on 9/4/14, at 1:48 p.m., NA-B stated the staff (NAs) struggles to get the assigned work load completed. NA-B stated getting shaving and grooming completed everyday was difficult, and the rehabilitation aide often is pulled from their duties to provide direct care for the residents because of low staffing. Further, NA-B stated, "I do feel staffing needs to be addressed." During interview on 9/4/14, at 2:21 p.m., registered nurse (RN)-B stated they noticed that no staff was consistently completing range of motion for the residents when the rehabilitation aide is pulled from their duties. RN-B said, "...we don't have someone to cover that [ROM services] now." LACK OF TIMELY CALL LIGHT RESPONSE BY STAFF AS SHOWN BY CALL LIGHT AUDITS: The facility provided call light reports for all units during the time period of August 27, 2014 to September 3, 2014, however only included the morning (12:02 a.m. through 8:16 a.m.) for August 31, 2014, and did not include August 30, 2014. The reports indicated the call lights were triggered 1668 times during that period, and of that 197 times they exceeded 10 minutes (range 10 minutes to 59 minutes 15 seconds in time) or 11.8% of the time, residents had to wait over 10 minutes to receive help and assistance. When interviewed on 9/4/14, at 4:24 p.m., the administrator stated several staff had recently left the facility to go back to school or participate in sports, and she was aware staffing was, "not at the optimum." Further, the administrator stated call lights should be answered within 6-9 minutes, and despite being aware of staffing concerns, no	2 800		

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2 800	Continued From page 11 written plan of action was developed by the facility Quality Assurance committee to address the concern. A facility policy on staffing and procedures was requested, but was not provided. ADDITIONAL STAFFING CONCERNS IDENTIFIED IN THE FOLLOWING TAGS THAT ADDRESS RESIDENT CARES AND SERVICES THAT WERE NOT PROVIDED AS RESIDENT SPECIFIC NEEDS WERE ASSESSED: See F241: Based on observation, interview and document review, the facility failed to enhance the resident ' s self-worth and self-esteem by providing and environment that promotes dignity for 2 of 2 residents (R28 and R53) who did not receive services that promoted dignity. R28 lacked clothing adjustments to cover abdomen. R53 lacked timely toileting needs and soiled self with urine while waiting for help. See F242: Based on interview, observation and document review the facility failed to follow identified family preferences related to care for 1 of 1 resident (R28) reviewed for choices. R28 ' s family wanted R28 to be up for meals at specific times and this was not accommodated. See F253: Based on observation, interview, and document review, the facility failed to maintain a clean room for 1 of 1 residents (R28) identified by family has not having a clean room. R28 ' s room had a thick layer of dust and debris on the floor. See F282: Based on observation, interview, and document review, the facility failed to implement resident care plan interventions to promote healing and/or prevent increase of a current	2 800		

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2 800	Continued From page 12 pressure ulcer for 1 of 3 residents (R3) reviewed with a pressure ulcer, in addition the facility failed to implement the care plan range of motion services for 3 of 3 residents (R3, R7, R12) reviewed who received these services. R3 was not repositioned for more than 2 hours and 34 minutes even though she had a stage three pressure ulcer on the coccyx. R3, R7, R12 did not receive consistent range of motion (ROM) services as staff were often pulled from nursing rehabilitative services to do direct care for residents. See F312: Based on observation, interview, and document review, the facility failed to provide necessary grooming for 2 of 3 residents (R5, R9) whom were dependent on staff for activities of daily living (ADL), whom were reviewed for ADL services. See F314: Based on observation, interview and document review, the facility failed to provide care to promote healing of a current pressure ulcer for 1 of 3 residents (R3) reviewed with a pressure ulcer. As with F282 R3 had not received repositioning services assessed to be done every 1.5 hours and R3 was allowed to go 2 hours and 34 minutes before being repositioned and pressure relieved on an open stage three pressure ulcer. See F318: Based on observation, interview, and document review, the facility failed to provide range of motion as recommended by physical therapy (PT) for 3 of 3 residents (R3, R7, R12) reviewed for range of motion. As stated in F282 these three residents were not provided ROM services due to the rehabilitative nursing assistant was pulled to help do direct resident cares and then the ROM services were not completed.	2 800		

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2 800	Continued From page 13 SUGGESTED METHOD OF CORRECTION: The Administrator and Director of Nursing could review their staffing patterns and develop ways to promote and recruit needed staff. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide range of motion (ROM) services as recommended by physical therapy for 3 of 3 residents (R3, R7, R12) reviewed for range of motion. Findings include: R3 ' s quarterly Minimum Data Set (MDS) dated 8/6/14; identified R3's diagnoses included	2 895		

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2 895	Continued From page 14 multiple sclerosis, had moderate impaired cognition, impaired functional limitation in range of motion to both sides of the upper and lower body, and had total dependence on staff for all areas of daily living (ADL). R3's care plan revised 7/11/14, identified R3 had impaired physical mobility, and had a restorative program that included, passive range of motion exercises including arm extensions, wrist flexion and extension, heel cord stretches, hamstring stretches, and knee bends for 12 to 15 repetitions with each exercise for a total of 15 minutes daily. During an observation on 9/4/1214, at 9:40 a.m. R3 was resting in bed with a pressure pad call light placed on her left shoulder. No ROM was noted to be done. Review of the ROM charting lacked any documentation that services were performed in the past 6 days. During an interview on 9/3/14, at 10:07 a.m. nursing assistant (NA)H confirmed she had not performed PROM exercises for R3 and, stated NA's do not do exercises or range of motion for the residents, "a rehab (rehabilitation) aid does them." R7 ' s quarterly MDS dated 6/4/14, identified R7 had diagnoses which included post cardio vascular attack (CVA) with left sided hemiparesis, had moderate cognitive impairment, functional limitation in range of motion with impairment on one side of the body, upper and lower, and required extensive assistance with activities of daily living. R7 ' s care plan revised 6/17/14, identified R7 had a restorative program of ROM to arms and legs daily.	2 895		

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2 895	Continued From page 15 During observation on 9/4/14, at 9:25 a.m. R7 was seated in a wheel chair with her left foot on a foot peddle, and left hand laying flaccid (Lacking firmness, resilience, or muscle tone) on her left thigh near the wheel chair arm rest. R7 ' s fingers were wrapped in a fist with the thumb inside the 4 fingers. During an interview on 9/4/14, at 4:15 p.m. R7 confirmed no exercise or ROM services were completed for her arm or legs today. Review of the ROM charting lacked documentation that services had been completed for the past 6 days. During an interview on 9/4/13, 8:36 a.m. NA-E stated "we do not have enough staff," since some staff returned to school and others have quit. " NA-E confirmed 2 rehabilitative (rehab) aids perform all exercise and ROM services. NA-E explained due to the shortage of staff, the rehab aids are moved into the nursing assistant position and no one performed the ROM services. During an interview on 9/4/14, 2:21 p.m. registered nurse RN-B confirmed ROM services for R3 and R7 were scheduled to be completed daily, and staff charted the services completed in the computer charting. RN stated when a rehab aid is needed to work as a nursing assistant "we don't have someone to cover that now," and the residents do not receive ROM services. During an interview on 9/4/14 at 3:53 p.m. the director of nursing (DON) confirmed the resident care plan for daily range of motion should be followed by staff. The DON stated if the rehab aid was pulled from the floor all staff should work together to complete all cares for residents	2 895		

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(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
2 895	Continued From page 16 include the daily ROM services. A requested facility policy for rehabilitative services was not provided. R12's physician visit form dated 7/22/14 indicated that R12's diagnoses included cerebrovascular accident (CVA), depression, hemiplegia, diabetes mellitus and coronary artery disease. The quarterly Minimum Data Set (MDS) dated 8/13/14 indicated that R12 had a score of 12 on the brief interview for mental status (BIMS) indicating R12 ' s cognition was moderately impaired. It also noted that R12 was extensive assistance of two staff with bed mobility, transfer, dressing toileting, personal hygiene, and was independent with eating after set up. The annual MDS dated 2/19/14 indicated that R12 had impairment on one side for upper and lower extremities. According to the certified nursing assistant's assignment card dated 7/11/14 for restorative, R12 had a CVA with right sided hemiplegia. According to the discharge physical therapy note dated 8/28/14 restorative nursing was directed to do the following for R12: Sit and glide (L) Lower extremity for 15 minutes. Continue with brace to stretch right knee and right knee extension passive range of motion exercise. R12's restorative plan of care dated 7/11/14 indicated that R12 had limited range of motion to the right leg related to her CVA. Instructions included assisting resident to apply knee brace to right side for up to 1 hour daily to aide in stretching of the knee and hamstring. The total time brace was left on was to be documented. The level of extension in degrees R12 was able to perform was to be documented. Documentation of the restorative nursing charting for R12 for August, 2014 and September, 2014	2 895		

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	00073	A. BUILDING: _____ B. WING _____	09/04/2014

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2 895	Continued From page 17 was reviewed. There was no documentation of restorative nursing from 8/1/14 through 8/7/14. There was no documentation of restorative nursing being completed from 8/23/14 to 9/4/14. An interview on 9/3/14 at 1:19 p.m. with the physical therapy aide, (PTA) she indicated that R12 was discharged from therapy on 8/28/14. The PTA indicated that R12 was to be on a sit and glide restorative program 15 minutes each day. During an interview with registered nurse (RN)-B, she confirmed that no documentation of restorative nursing had been done since 8/23/14 and that there were gaps in the August, 2014 documentation. RN-B stated that the stretch for the right leg should have been done and that the new recommendation should have been put into place. The director of nursing (DON) on 9/4/14 at 1:58 p.m. stated that she wasn't aware of the recommendation from therapy. The DON indicated that one of the registered nurses yesterday noted that there was a recommendation from therapy for the sit and glide. The DON stated that usually therapy will give recommendations and then the recommendations are given to the restorative nurses and put on the restorative care plan. The DON on 9/4/14 at 4:50 p.m., stated they had no policy for the restorative program. SUGGESTED METHOD OF CORRECTION: The director of nursing could review their restorative nursing program to ensure that range of motion was being provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		

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2 900	Continued From page 18	2 900		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide care and services to promote healing of a current stage three pressure ulcer for 1 of 3 residents (R3) reviewed with a pressure ulcer. Findings include: R3 had not received repositioning to relieve pressure on the coccyx area with the stage three pressure ulcer for more than 2 hours and 34 minutes even though R3 was assessed to need repositioning every 1.5 hours to promote healing and prevent other ulcers from developing. R3 had diagnoses which included Multiple sclerosis, and Diabetes Type 2 adult onset found	2 900		

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2 900	Continued From page 19 on the face sheet. The quarterly Minimum Data Set (MDS) dated 8/6/14; identified R3 had a stage 3 pressure ulcer (full thickness tissue loss, exposing the subcutaneous tissue) and, was incontinent of bowel and bladder. R3's care plan revised 6/24/14, identified R3 had "impaired skin integrity," and had a repositioning schedule of 1.5 hours when in bed and a check and change of incontinent liners every 2 hours. Review of the weekly skin assessment for past three month (June, July, August and September 1, 2014), identified various interventions which included a turning and repositioning schedule. During an interview on 9/4/14 at 7:07 a.m. nursing assistant (NA)-K confirmed nursing assistants logged the time residents were provided cares and used the computer to track the next time care was to be provided. NA-K confirmed R3 was scheduled to receive cares which includes toileting and/or repositioning at 7:53 a.m. During observations on 9/4/14, from 7:06 a.m. to 8:49 a.m. the following was noted: 7:06 a.m. R3 was in bed positioned on her back with a pillow under the right side of her body. 8:25 a.m. R3 remained on her back with the pillow in the same position. 8:29 a.m. R3 remained in same position. 8:49 a.m. R3 remained in the same position. 8:49 a.m. continuous observation of R3 began. R3 remained in the same position on her back with the pillow under her right side, with no staff entering the room until 9:40 a.m. when nursing assistant (NA)-H entered the room to provide morning cares. R3's incontinent liner was	2 900		

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2 900	Continued From page 20 saturated with urine and, a 2 inch square dressing was in place on the coccyx which was soiled on one edge with sanguineous (blood) drainage. R3 had not received incontinent care nor been repositioned for 2 hours and 34 minutes plus the time before observations started at 7:06 a.m. During an observation on 9/3/14, at 1:40 p.m. licensed practical nurses (LPN)-B, along with NA-H performed a dressing change to the ulcer. The ulcer was circular, with a diameter of 2 centimeters; the tissue was " beefy " red in color with a pink scarred area around the perimeter. During an interview on 9/3/14, at 10:07 a.m. NA-H confirmed staff had not checked, changed or repositioned R3 this morning, and this was a typical morning for R3. NA-H stated, "The 6 o'clock person [NA] does rounds in the morning" and confirmed 9:40 a.m. was the first time NA-H had entered R3's room. During an interview on 9/3/14 at 1:40 p.m. LPN-B stated staff is expected to check and change incontinent products and reposition R3 when in bed every 2 hours (However, the care plan for R3 read 1.5 hours for repositioning.) During an interview on 9/4/14, at 2:23 p.m. registered nurse (RN)-B, stated staff is expected to follow care plan to reposition and check and change residents. During an interview on 9/4/14 at 3:53 p.m. the director of nursing (DON) confirmed staff are expected to follow the care plan to check, change and reposition residents. The requested facility policy for pressure ulcer	2 900		

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2 900	Continued From page 21 cares was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service all staff responsible for resident cares and services provides services as directed by the comprehensive care plan. Also to audit for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. 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 MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide necessary grooming for 2 of 3 residents (R5, R9) whom were dependent on staff for activities of daily living (ADL), whom were reviewed for ADL skills. Findings include: R5's quarterly Minimum Data Set (MDS), dated 7/2/2014, identified moderate cognitive impairment, and that R5 needed extensive assistance with personal hygiene and dressing. The care plan, updated 4/21/2014, indicated R5 needed the assist of one to clip her nails on bath	2 920		

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2 920	Continued From page 22 days, and to make sure R5's clothing and appearance is neat and comfortable in appearance. During observation on 9/2/2014 at 3:45 p.m., R5 was seated in a recliner in her room, looking at a newspaper. R5 had numerous, unshaven facial hairs on her chin, approximately one-half inch in length. During an interview on 9/3/2014 at 11:15 a.m., R5 stated she had a bath earlier in the morning, but said her fingernails "were not trimmed." R5 then took off her socks, exposing her feet. R5 then said, "Look at my toenails, they are ridiculous, and haven't been cut in I don't know how long." The surveyor asked R5 if she groomed facial hair by herself, and R5 responded, "No, and I don't like how it looks." R5 said the "girls" usually trim her chin hair, and they also cut nails on her bath day. R5 stated, "That didn't get done; none of that got done." In an interview on 9/3/2014 at 2:36 p.m. licensed practical nurse (LPN)-A verified she bathed R5 earlier in the day, but that she did not yet clipped R5's finger or toenails, nor groomed her chin hair. LPN-A stated that the shaving of facial hair and cutting of nails were "routinely completed during resident baths." During observation of morning cares on 9/4/2014 at 9:19 a.m., R5's facial hair remained uncut, and R5's fingernails and toenails also had not been groomed. During an interview on 9/4/2014 at 9:42 a.m., nursing assistant (NA)-B verified R5 had facial hair on her chin, that her toe nails and fingernails were all in need of trimming. NA-B stated, "That	2 920		

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2 920	Continued From page 23 should have been done along with R5's weekly bathing." During an interview on 9/4/2014 at 3:36 p.m., LPN-B stated, "I would expect," when a resident is given a bath, "hair and nail care be completed," and that "facial grooming" for the resident also be completed. In an interview on 9/4/2014 at 4:30 p.m., the director of nursing (DON) stated that each resident needed to be asked what specific grooming he or she wanted, and then provide assistance as needed. If a resident is unable to do for him or herself, the DON said, "I would expect we groom that resident." A facility policy regarding resident grooming was requested, but none was provided. R9's significant change in status Minimum Data Set (MDS), dated 7/30/14, indicated R9 was cognitively intact, displayed no behavioral symptoms, and required supervision of staff to ensure personal hygiene care was completed. R9's care plan, dated 7/29/14, indicated R9 required dependent assist from nursing staff to complete grooming. R9 was observed on 9/2/14 at 5:03 p.m. to be lying in bed. R9 had black and white facial hair on her upper lip. During subsequent observations on 9/3/14, at 8:23 a.m. and 1:55 p.m., R9 remain in bed with facial hair on her upper lip. During interview on 9/4/14, at 7:30 a.m., nursing assistant (NA)-D stated R9 normally did not have facial hair. NA-D stated facial hair should be removed with routine care unless there is a	2 920		

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2 920	Continued From page 24 preference to have it. NA-D stated R9 did not have a personal preference for facial hair to her knowledge, and it should have been removed when staff completed personal hygiene cares. When interviewed on 9/4/14, at 7:56 a.m., licensed practical nurse (LPN)-B stated R9 was completely dependent on staff for personal hygiene and grooming. LPN-B further stated R9's facial hair should have been removed. During interview on 9/4/14, at 9:16 a.m., registered nurse (RN)-B stated R9 was completely dependent on staff to have grooming and personal hygiene completed. RN-B stated R9 would have an identified preference in the care plan if she desired to have facial hair; however acknowledged R9 had no such documentation in her care plan. RN-B further stated R9's facial hair should have been removed. When interviewed on 9/4/14, at 1:58 p.m., the director of nursing (DON) stated women should be shaved promptly if facial hair is observed unless they have an identified preference to have it. The DON further stated she didn't feel R9's unshaved facial hair was an issue of concern. A facility policy on grooming and personal hygiene was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing could provide education on the performance of providing activities of daily living and follow up with audits/observation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		

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21426	Continued From page 25	21426		
21426	MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to complete the required two step tuberculin skin test (TST) upon admission for 1 of 5 residents (R44) reviewed for immunizations. Findings Include: R44's admission Minimum Data Set (MDS), dated 8/12/14, indicated R44 admitted to the facility on 8/5/14. R44's immunization record, undated, indicated	21426		

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21426	Continued From page 26 R44 received a single step Purified Protein Derivative (PPD), also known as a TST, on 8/5/14. The record indicated the results of the single step to be 0 mm (millimeters). R44's immunization record did not indicate a second TST had been completed. During interview on 9/3/14, at 12:44 p.m., registered nurse (RN)-B stated R44 should have been given a second TST. RN-B further stated all new admissions receive a 2 step TST unless contraindicated. When interviewed on 9/4/14, at 2:06 p.m., the director of nursing (DON) stated all residents should receive a two step TST when they admit to the facility, and R44 should have been given a two step TST. A facility OSHA Occupational Exposure to TB Control Plan policy, dated 7/2011, indicated an effective infection control program requires early detection, evaluation, referral, and treatment, including use of TST's to determine if new residents and/or team members (staff) have tuberculosis (TB) infection or disease. A facility Tuberculosis Screening - Residents policy, dated 9/2014, indicated a two step TST should be performed. SUGGESTED METHOD OF CORRECTION: The facility could designate an employee that would be responsible to ensure that all new employees received and had read their mantoux before they would be allow to begin work with the residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		

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21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure emergency medications were not expired and available for resident use. This had the potential to affect all 49 residents residing in the facility. During routine review of the medication storage 9/3/14, at 2:57 p.m. with registered nurse (RN)-C, the emergency kit was checked for medication storage. There were two vials of Lorazepam (to treat anxiety) were observed to have been expired. The printed expiration date was 4/14, having been expired for 5 months. During an interview on 9/3/14, at 3:05 p.m. RN-C confirmed the expired vials of Lorazepam, and that the pharmacist was responsible for checking the emergency kit. During an interview on 9/4/14, at 3:53 p.m. the director of nursing (DON) confirmed the pharmacist "switched out" the emergency medications, however, the DON believed nursing staff had been reviewing expiration dates. The DON confirmed the expectation had been that emergency medications would not be out dated. During an interview via phone on 9/5/14, at 1:40 p.m. the consulting pharmacist-A stated he did not review emergency medications that would be the responsibility of the pharmacy that provided the medications. The requested facility policy concerning	21620		

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21620	Continued From page 28 emergency kits and medication storage was not provided. SUGGESTED METHOD OF CORRECTION: The facility could work with the registered pharmacist on a policy and procedure to ensure that expired medications in the e-Kit would be destroyed to ensure that they would not be used. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21620		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview the metal storage areas in the kitchen were not maintained in a state of good repair to promote a sanitary surface. This affected all 46 residents in the facility who ate foods provided from the utensils located on the metal storage areas. Findings include: During a kitchen tour on 9/3/14 at 3:02 p.m. the assistant dietary manager verified the metal storage areas where pans and salad containers were stored and the metal shelf underneath the	21685		

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21685	Continued From page 29 food preparation station had peeling, rough, uneven chipped paint that created a surface that was unable to be cleaned and sanitized. During a kitchen tour on 9/3/14 at 3:07 p.m. the administrator verified the metal storage areas where pans and salad containers were stored and the metal shelf underneath the prep station had peeling, rough, uneven chipped paint that created an un-cleanable surface. The administrator stated the metal storage areas in the kitchen had been sandblasted and repainted in the past and stated the facility would have to look into options to have these areas repaired. Facility policies were requested for cleaning of freezers and maintaining storage areas in the kitchen with cleanable surfaces and none were provided. Based on observation, interview and document review the facility failed to maintain a freezer in good working order for 1 of 4 freezers observed during the initial kitchen tour. This had the potential to affect all 49 residents living in the facility who receive food from the kitchen. Findings Include: During the initial kitchen tour on 9/2/14 at 1:12 p.m., a white upright freezer was observed to have a heavy buildup of frost and ice on the three internal shelves and the freezer ceiling. The freezer contained one box of sausage links, one box of bacon, one box of French toast, one box of pancakes, one box of frozen berries, two plastic containers of strawberries, one bag of cinnamon roll dough, and 1 box of eggs. The dietary manager (DM) verified all three shelves and the ceiling had an inch or more of thick frost and ice buildup. The DM stated the freezer was to be cleaned out every six months and stated it was	21685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00073	A. BUILDING: _____ B. WING _____	09/04/2014

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21685	Continued From page 30 due to be cleaned. The DM stated he was the delegated staff person responsible for cleaning the freezer. During an interview on 9/3/14 at 11:24 p.m. the DM stated the white upright freezer was not on a schedule to be cleaned and was not on the deep cleaning list. The DM stated he was unsure the last time the freezer had been cleaned as there was no record. Facility policies were requested for ongoing maintenance of the freezers and none was provided. SUGGESTED METHOD OF CORRECTION: The administrator could inservice maintenance to have a system on place to monitor and fix equipment that is not working as manufactures specifications and kitchen shelves and areas that are chipping paint be refurbished or replaced to maintain and environment that is sanitizable. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview and document	21695		

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	00073	A. BUILDING: _____ B. WING _____	09/04/2014

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21695	Continued From page 31 review, the facility failed to maintain a clean room for 1 of 1 resident (R28) identified by family as not having a clean room. Findings include: During an interview on 9/2/14 at 7:00 p.m., when asked, " Is the building clean? " family members (FM)-A and FM-B answered, " No, the furniture is dusty; the nursing assistants are to clean residents ' rooms along with their other responsibilities." FM-A took her finger and swiped it across the china cabinet in R28's room to demonstrate the china hutch was covered with dust and there was a buildup of dust noted on the china hutch. FM-A and FM-B stated they had shared these concerns with facility staff. Review of a progress noted dated 6/12/14 at 2:57 a.m. and 11:30 a.m., revealed family members had visited R28 yesterday evening and were very upset and stated R28's room was dirty. During an interview on 9/4/14 at 9:17 a.m. nursing assistant (NA)-C verified the floor in R28 ' s room was " dirty " and needed to be swept and the china cabinet was dusty. NA-C stated she, " tried to clean resident rooms when residents were in activities between 1:30 p.m. and 2:00 p.m." NA-C stated that gave her, "thirty minutes to clean eight residents rooms" on her assigned wing during her shift. NA-C stated room cleaning was the task that she was assigned that, "doesn't get done the most." During an interview on 9/4/14 at 9:47 a.m. the administrator verified the floor in R28's room was soiled with debris and needed to be swept and the china cabinet was dusty. The administrator stated the staff should sweep and mop the floor	21695		

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21695	Continued From page 32 one to two times a week and stated, "Sweeping should be done whenever there is soiling." The administrator stated the china cabinet should be dusted on a weekly basis. The administrator stated the person that was caring for the resident was responsible for cleaning their room. The administrator also stated the housekeeping supervisor and her assistant who just started on Tuesday were also responsible to clean resident rooms. The administrator stated the facility had been without an assistant housekeeper all summer and explained the assistant housekeeper's roll was to assist with sweeping and dusting in resident rooms. The administrator stated the facility worked off of the household model. The administrator stated she was aware of the concerns with residents' room being clean and stated the facility was working on this. The administrator stated she was aware of concerns related to the cleanliness of R28's room as the family had voiced concerns and verified there was documentation of family concerns in progress notes dated June 12, 2014 and stated audits had been completed by the director of nursing related to the cleanliness of R28 ' s room. The administrator stated to her knowledge there had been no further concerns after the audits had been completed. The policy titled Caledonia Care and Rehab Housekeeping Program Policy and Guidelines dated 4-2014 read, " Policy: Caledonia Care and rehab will provide a safe, sanitary and comfortable environment. Guidelines: 1. Direct Care professionals utilize the cleaning schedules as provided in the "housekeeping daily task books" as part of the housekeeping program ..." SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop,	21695		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALEDONIA CARE AND REHABILITATION CEN	425 NORTH BADGER STREET CALEDONIA, MN 55921

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21695	Continued From page 33 review, and/or revise policies and procedures to ensure resident rooms are kept clean. The administrator or designee could educate all appropriate staff on the policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	21695		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to enhance the resident ' s self-worth and self-esteem by providing and environment that promotes dignity for 2 of 2 residents (R28 and R53) who did not receive services that promoted dignity. Findings include: R28's quarterly Minimum Data Set (MDS) dated 5/28/2014 revealed R28 had diagnoses of Dementia, Depression, Parkinson's disease and Anxiety Disorder. R28 had severe cognitive impairment and was rarely/never understood. R28 required total dependence with two staff with bed mobility, transfers, dressing, bathing, toilet	21805		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALEDONIA CARE AND REHABILITATION CEN	425 NORTH BADGER STREET CALEDONIA, MN 55921

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21805	Continued From page 34	21805		

use, and personal hygiene, total dependence of one staff for locomotion on and off the unit and for eating. The care plan dated 4/14/14 indicated R28, "Can respond at times appropriately to simple questions, but doesn't always do so."

During an interview on 9/2/14 at 6:41 p.m., when asked if staff treat R28 with respect and dignity, family members (FM)-A and FM-B answered, "No. Sometimes we have concerns about [R28's] clothes. We will come and visit and [R28's] skin will be exposed. FM-A and FM-B gave example of R28's pants not being pulled up correctly. FM-A and FM-B stated, "We have talked to them [staff] about this and treating [R28] with dignity."

During an observation on 9/3/14 at 1:03 p.m., licensed practical nurse (LPN)-C verified R48 was sitting in the recliner in R28's room and stomach skin was exposed above R28's pants. LPN-C stated staff should have positioned R28's clothing to not expose the stomach skin, and verified R28 was unable to adjust the shirt on their own. LPN-C verified having stomach skin exposed was a dignity concern.

During an interview on 9/3/14 at 4:10 p.m., the administrator stated she expected staff to rearrange clothing to prevent skin from being exposed after using the lifts and after repositioning residents. The administrator verified residents having stomach skin exposed was a dignity concern.

A policy was requested on caring for residents with respect and dignity. The facility did not provide a facility policy, however provided a copy of an excerpt from the facility website that read, "We are committed to providing an environment in which all people are treated with kindness,

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	00073	A. BUILDING: _____ B. WING _____	09/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALEDONIA CARE AND REHABILITATION CEN	425 NORTH BADGER STREET CALEDONIA, MN 55921

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21805	Continued From page 35 dignity and respect, no matter their physical impairment or mental condition." The resident bill of rights dated 7/1/07, directed the, "Facility must with courtesy promote and care for you in a manner and environment that maintains or enhances your dignity and respect in full recognition of your individuality." R53's admission MDS assessment, dated 5/23/2014, indicated intact cognition. The MDS further indicated R53 required extensive assistance from staff, with the physical assistant of one, for toileting and dressing, and the physical assistance of two persons for transferring. During an interview on 9/4/2014 at 9:49 a.m., R53 stated he had, "an accident yesterday" on asking what he meant by accident R53 said that he soiled himself because he did not receive timely assistance to toilet. R53 said he had just returned to the nursing home after an outing in the morning, went to his room and put the call light on and waited. R53 said he "wet himself " with urine because he had to wait too long for assistance. R53 then said he had to use the bathroom a second time later that morning, and went into the bathroom without staff assistance. R53 said, "I pushed the [call] light on, after I was on the toilet." R53 stated he was not to use the toilet without staff help. R53 said he has fallen asleep in his chair waiting for staff to come and answer a call light. R53 said he had waited so long for assistance after activating the call light without staff response, that he called the nursing home phone with his personal telephone to request assistance. R53 added that he has also "called home " and " called my son in Texas " and had them call the nursing home, letting staff know I wanted help. R53 said, "I believe they [the nursing home] have too many residents here for	21805		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALEDONIA CARE AND REHABILITATION CEN	425 NORTH BADGER STREET CALEDONIA, MN 55921

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21805	Continued From page 36 the number of staff they have." During an interview on 9/4/2014 at 9:44 a.m., nursing assistant (NA)-B stated that "by and large" we do get our toileting an repo [repositioning] completed, and on time. " NA-B acknowledged that there were times when residents had accidents, because staff could not assist them as quickly as needed. Then NA-B said, "That's likely what happened with [R53], and that should not have happened." During an interview on 9/4/2014 at 3:36 p.m., LPN-B stated residents needed to be toileted in a timely manner, and agreed soiling oneself is not acceptable. LPN-B stated, "It is a matter of dignity for a resident." In an interview on 9/4/2014 at 4:30 p.m., the director of nursing (DON) stated, that each resident should receive assistance as needed. SUGGESTED METHOD OF CORRECTION: The Director of Nurses could have an educational in-service on treating resident's with dignity and follow up with audits for dressing, grooming and toileting. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the	21830		

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	00073	A. BUILDING: _____ B. WING _____	09/04/2014

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21830	Continued From page 37 opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and	21830		

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21830	Continued From page 38 (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.	21830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21830	Continued From page 39 This MN Requirement is not met as evidenced by: Based on interview, observation and document review the facility failed to follow identified family preferences related to care for 1 of 1 resident (R28) reviewed for choices. Findings Include: R28's quarterly Minimum Data Set (MDS) dated 5/28/2014 revealed R28 had diagnoses of Dementia, Depression, Parkinson's disease and Anxiety Disorder. R28 had severe cognitive impairment and was rarely/never understood. R28 required total dependence with two staff with bed mobility, transfers, dressing, bathing, toilet use, and personal hygiene, total dependence of one staff for locomotion on and off the unit and for eating. The care plan dated 4/14/14 indicated R28, " Can respond at times appropriately to simple questions, but doesn't always do so." Review of progress note dated 6/3/13 read, " SPECIAL REQUEST: give meals at 8:30 am, 12:30 pm and 4:30 pm. All meals served in own room or east alcove area for 'quiet environment to promote optimal intake'. Resident is assisted with oral foods/fluids and supplement intake." R28's care plan and nursing assistant assignment card were reviewed and did not address what time in the morning family had requested R28 to be up for the day or what times family had requested R28 to have meals. During an interview on 9/2/14 at 6:33 p.m., family members (FM)-A and FM-B were asked, " Does [R28] get up in the mornings according to his/her previous routine?" FM-A and FM-B answered, "	21830		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALEDONIA CARE AND REHABILITATION CEN	425 NORTH BADGER STREET CALEDONIA, MN 55921

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21830	Continued From page 40 No. We would like [R28] to have [R28's] Parkinson medication around 8:00 a.m. and be out of bed around 8:30 a.m. in the morning. There have been times when we have come to visit and it has been 9:30 a.m. to 10:00 a.m. and [R28] is still in bed, partially dressed but not up." FM-A and FM-B stated they have discussed these preferences with staff and it continues to be a concern. They stated they have addressed these concerns during care conferences and address these concerns immediately with the staff working when they visit and she is still in bed at 9:30 a.m. to 10:00 a.m. when they arrive at the facility. FM-A and FM-B also voiced a concern related to R28 not receiving meals at the same time other residents received their meals in the dining room and stated there had been times when R28 was served after the clean-up of the meal had already been completed in the dining room. FM-A and FM-B stated they had voiced their concerns regarding resident being served later than other residents and their preferences for R28's meals times with facility staff. During an interview and observation on 9/3/14 at 9:20 a.m. nursing assistant (NA)-B stated she provided morning cares and got R28 dressed around 7:30 a.m. that morning, and stated R28 remained in bed at that time. NA-B stated at 9:20 a.m. they finished R28's cares and were getting R28 up for the day. NA-B stated R28 had breakfast at table in hall per family preference and stated the time of breakfast varied as R28 needed to take Parkinson's medication and had to wait thirty minutes after receiving the medication to eat. NA-B stated staff got R28 up around this same time approximately 9:30 a.m. on a regular basis. When NA-B was asked if she was aware of a family preference for a time for	21830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21830	Continued From page 41 R28 to get up in the morning, NA-B stated, " They would like [R28] up earlier but they are not able to get [R28] up earlier if we are busy with the other residents." And stated she thought family would like R28 up for the day at 9 a.m. in the morning. NA-A was also present in the room at the time of the interview and observation stated she thought family wanted R28 up for the day by "10:00" a.m. and stated R28 received the Parkinson's medication at 8:00 a.m. in the morning. During an observation on 9/3/14 at 9:48 a.m., NA-B was observed to be assisting R28 to eat breakfast. During an observation on 9/3/14 at 11:47 a.m., R28 was observed to be sitting in the east alcove area in a Broda chair slightly reclined with eyes closed. During an observation on 9/3/14 at 12:08 p.m., R28 was observed to be sitting in the east alcove area in a Broda chair slightly reclined with eyes closed. R28 had not been observed to have lunch. During an observation on 9/3/14 at 12:45 p.m., R28 was observed to be in the recliner in R28's room with eyes closed and the lights in the room turned off. R28 had not been observed to have lunch. During an observation on 9/3/14 at 1:29 p.m., R28 was observed to be in the recliner in R28's room with eyes closed and the lights in the room turned off. R28 had not been observed to have lunch.	21830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALEDONIA CARE AND REHABILITATION CEN	425 NORTH BADGER STREET CALEDONIA, MN 55921

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21830	Continued From page 42 During an observation on 9/3/14 at 1:38 p.m., R28 was observed to be in the recliner in R28's room with eyes closed and the lights in the room turned off. R28 had not been observed to have lunch. During an observation on 9/3/14 at 1:40 p.m. the licensed social worker (LSW)-A was observed to enter R28 to complete a social service visit. During an observation and interview on 9/3/14 at 1:47 p.m. NA-E was observed to assist R28 to eat lunch. NA-E stated R28, " normally had lunch between 1:00 and 1:30 p.m." and stated R28 would have supper around 5:00 p.m. that evening. NA-E stated R28's, "eating times were different than the other residents in the facility because of family preferences." NA-E stated family wants R28, " up early by 8:30 a.m. or someone in there. I know they have requested her to be up early. NA-E stated, " Family wanted [R28] to eat breakfast around 10:00 a.m." NA-E stated staff was made aware of family preferences for resident cares verbally through report. During an observation and interview on 9/3/14 at 1:55 p.m. registered nurse (RN)-A verified R28 was being assisted to eat lunch at 1:56 p.m. and verified documentation of family request for R28 to have meals at 8:30 a.m., 12:30 p.m. and 4:30 p.m. During an observation and interview on 9/4/14 at 9:17 a.m., NA-C and NA-D were observed to be getting R28 out of bed for the day. NA-C stated she normally got R28 up for the day between 8:30 a.m. and 9:00 a.m. in the morning. NA-C stated staff went by R28's two hour turning schedule and when R28 received her Parkinson's medication	21830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00073	A. BUILDING: _____ B. WING _____	09/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALEDONIA CARE AND REHABILITATION CEN	425 NORTH BADGER STREET CALEDONIA, MN 55921

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21830	Continued From page 43	21830		

for when they got R28 up for the day and for the time R28 received meals. NA-C stated if family had a preference for meal times or time of the day for R28 to get up for the day the preference would listed on the nursing assistant care plans. NA-C stated R28 was to have lunch around 12:30 p.m.

During an observation on 9/4/14 at 10:00 a.m. R28 was observed to be having breakfast.

During an interview on 9/4/14 at 9:47 a.m. the administrator stated she was unaware family had requested specific meal times and a specific time in the morning for staff to get R28 up for the day. The administrator stated she expected residents to be served lunch before 2:00 p.m. and stated meals should be served to R28 by the schedule that has requested by family and stated staff should get R28 out of bed in the morning by the time the family has requested.

During an observation on 9/4/14 at 1:20 p.m., R28 was observed to be having lunch.

During an interview on 9/4/14 at 2:31 p.m. the director of nursing (DON) stated if there was a family request for a resident to eat meals at specific times or for a resident to get out of bed in the morning at a specific time, the facility should try to try to accommodate these requests and have the resident eat close to the requested times and get out of bed in the morning close to the requested time. The DON stated she was unaware of specific family requests for R28 to get out of bed for the day in the morning or specific time ' s family had requested R28 to have meals. The DON stated when family makes specific requests related to residents' cares the specific requests should be added to the residents ' care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00073	A. BUILDING: _____ B. WING _____	09/04/2014

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21830	Continued From page 44 plan for staff to follow. The DON verified R28's family requests for meal times and when to get R28 out of bed in the morning were not on the care plan. A facility policy was requested on resident ' s choices and was not provided. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop policies and procedures regarding resident choices, educate staff, and conduct audits to ensure identified family preferences for cares and routines are followed by staff. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21830		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3051 2880

September 18, 2014

Ms. Marian Rauk, Administrator
Caledonia Care And Rehabilitation Center
425 North Badger Street
Caledonia, Minnesota 55921

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5499021

Dear Ms. Rauk:

The above facility was surveyed on September 2, 2014 through September 4, 2014 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:

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

Enclosure(s)

cc: Original - FacilityLicensing and Certification File