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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: CVDE

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00125

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245528**
2.STATE VENDOR OR MEDICAID NO.
(L2) **978740200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GUNDERSEN HARMONY CARE CENTER**
(L4) **815 MAIN AVENUE SOUTH**
(L5) **HARMONY, MN** (L6) **55939**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/27/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **43** (L18)
13.Total Certified Beds **43** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With
Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	43			
(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 — 03/06/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Shellae Dietrich, Certification Specialist — 07/26/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 07/27/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/03/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 24-5528 July 26, 2017

Ms. Michelle Borreson, Administrator
Gundersen Harmony Care Center
815 Main Avenue South
Harmony, Minnesota 55939

Dear Ms. Borreson:

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 February 1, 2017, the above facility is certified for:

43 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Certification Specialist
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

March 6, 2017

Ms. Michelle Borreson, Administrator
Gundersen Harmony Care Center
815 Main Avenue South
Harmony, MN 55939

RE: Project Number S5528027

Dear Ms. Borreson:

On January 23, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 12, 2017. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On February 27, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 7, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 12, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 1, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 12, 2017, effective February 1, 2017 and therefore remedies outlined in our letter to you dated January 23, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245528 Y1	A. Building B. Wing Y2	2/27/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GUNDERSEN HARMONY CARE CENTER	815 MAIN AVENUE SOUTH HARMONY, MN 55939

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0280	Correction	ID Prefix F0312	Correction	ID Prefix F0334	Correction
Reg. # 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2)	Completed	Reg. # 483.24(a)(2)	Completed	Reg. # 483.80(d)(1)(2)	Completed
LSC	02/01/2017	LSC	02/01/2017	LSC	02/01/2017
ID Prefix F0441	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	02/01/2017	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GPN/kfd	3/6/2017	10160	2/27/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
1/12/2017

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245528	A. Building 01 - MAIN BUILDING B. Wing	2/7/2017

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GUNDERSEN HARMONY CARE CENTER	815 MAIN AVENUE SOUTH HARMONY, MN 55939

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0923	Correction Completed 01/23/2017	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 3/6/2017	SIGNATURE OF SURVEYOR 37008	DATE 2/7/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/12/2017	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: CVDE

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00125

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245528**

2. STATE VENDOR OR MEDICAID NO. (L2) **978740200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GUNDERSEN HARMONY CARE CENTER**
(L4) **815 MAIN AVENUE SOUTH**
(L5) **HARMONY, MN** (L6) **55939**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **01/12/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **43** (L18)

13.Total Certified Beds **43** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	43			
(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 :
Sarah Strenke, HFE NE II 01/31/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/06/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1988
(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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 23, 2017

Ms. Michelle Borreson, Administrator
Gundersen Harmony Care Center
815 Main Avenue South
Harmony, MN 55939

RE: Project Number S5528027

Dear Ms. Borreson:

On January 12, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D). A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: 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 February 21, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 12, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 12, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245528	A. BUILDING _____ B. WING _____	01/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUNDERSEN HARMONY CARE CENTER	815 MAIN AVENUE SOUTH HARMONY, MN 55939

(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. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the	F 280		2/1/17

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

Electronically Signed | 01/31/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245528	A. BUILDING _____ B. WING _____	01/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUNDERSEN HARMONY CARE CENTER	815 MAIN AVENUE SOUTH HARMONY, MN 55939

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F 280	Continued From page 1 right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 280		

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F 280	Continued From page 2 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to revise the care plan for 1 of 3 residents (R2) related to missing teeth, who was reviewed for dental status and failed to develop a plan of care that included monitoring for side effects of an anti-coagulant medication (Warfarin) for 1 of 5 residents (R24) reviewed for unnecessary medications. Findings include: R2's care plan last reviewed/revised dated 9/16/16, identified dental care problem and has own teeth. Denies problems with dentition. Approach: assist setting up dental visit if should request this. Provide supplies for oral care. Set up and assist as needed for oral care. However, R2's care plan failed to identify R2 had missing teeth. On 1/10/17, at 2:07 p.m., observation of R2's	F 280	F280 Gundersen Harmony Care Center will continue to ensure a comprehensive plan of care is developed by the interdisciplinary team, allowing the resident and/or the resident representative to participate in the development and revisions of the person-centered plan of care for each individual resident. R2's plan of care was revised to include identifying missing teeth. R24's plan of care was revised to include monitoring for side effects of anti-coagulant medication. Case Manager will continue to ensure all other residents in the facility will have up to date care plans. All residents will be reviewed for comprehensive care plans as their next RAI review comes up during the next quarter, on all new admissions, and with significant changes. QA nurse to monitor for accuracy through chart audits aligned	

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F 280	Continued From page 3 teeth, identified R2 had missing teeth on the bottom gum line. R2 stated she had missing teeth on the top and bottom. R2's facility Oral Health Assessment, observation/date recorded date, 11/30/16, identified condition of teeth none of the above were present. Plan of care: continue current plan of care, denies problems with chewing, says she eats mostly soft foods. On 1/12/17, at 12:56 p.m., the director of nursing (DON) stated she would expect the facility oral assessment to identify missing teeth and missing teeth to be care planned if identified. LACK OF CARE PLANNING INTERVENTIONS ADDRESSING USE OF ANTICOAGULATION THERAPY: R24's current physician order's identified an order for Warfarin, start date 1/6/17, two milligrams (mg) on Sunday, Monday, Tuesday, Wednesday, Thursday and Saturday and 1 mg on Friday for diagnoses of pulmonary embolism and embolism and thrombosis of arteries of the lower extremities. R24's Medication Administration Record dated 1/1/17 through 1/12/17, identified R24 was receiving the medication as ordered. R24's care plan, dated last reviewed/revised: 1/2/17, problem: has diagnoses of history of pulmonary embolus, DVT (deep vein thrombosis), osteoporosis, dementia with psychosis, history of kidney failure, ankylyzing spondilosis. Approach: administer medications per provider's orders. Nursing staff will dispense and administer all medications. Monitor condition routinely by vital signs and weights per facility protocol. Obtain	F 280	with MDS schedule. Completion Date: 2/1/17	

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F 280	Continued From page 4	F 280		

consults PRN (as needed). Obtain scheduled labs per provider's orders. Problem last reviewed/revised: 1/2/17: uses PPI (proton pump inhibitor) for diagnosis of history of gastric ulcer and use of anticoagulant due to history of pulmonary embolism and DVT. Approach: Consider an attempt gradual dose reduction of PPI. If already on lowest scheduled dose, consider changing PPI to PRN prior to discontinuation and monitor symptoms and the use of PRN PPI use. Consult with dietary department to determine what foods may trigger increased symptoms of GERD (Gastroesophageal reflux disease) and reduce the frequency of foods in diet or avoid them completely. Encourage resident to remain upright for at least 30 minutes after meals. Request pharmacy consultant review medications to determine if other medications are on regime that could make dyspepsia symptoms worse. Consider alternative medications if possible.

However, R24's care plan had not addressed risk factors and interventions for excessive bleeding associated with the use of Warfarin in order to alert care givers the need to report bruising and bleeding timely to the nurse.

On 1/12/17, at 12:57 p.m., the DON confirmed R24's care plan failed to include risk factors and interventions associated with the use of Warfarin.

The facility policy Resident Care Plan, dated 11/26/16, indicated resident care plan documentation and use of the plan 5. The resident care plan must be kept current at all times. Concerns and problems Problem 2. Consider listing possible risks and complications. Approach/Plan 1. List all care to be provided for

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F 280	Continued From page 5 the problem listed. The care must be necessary and appropriate to accomplish the goal stated. 2. Coordinate all care to be provided to the resident for the most effective, efficient utilization of resources 3. Individualized care for the unique needs of the resident 4. Communicate vital information to all staff providing direct resident care.	F 280		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) 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 apply a t-shirt or offer the use of a t-shirt during assist with dressing for 1 of 3 residents (R24) reviewed for activities of daily living. Findings include: R24's annual Minimum Data Set (MDS), dated 9/29/16, identified R24 required extensive assist of one for dressing and had moderate cognitive impairment. During interview of family member (FM)-B on 1/10/17, at 4:29 p.m., when asked does R24 get the help she needs getting dressed, toileting, or cleaning her teeth? FM-B had stated they (the staff) do not put enough clothes on her when she is dressed. She needs a t-shirt on, I brought some t-shirts for her to use.	F 312	F312 Gundersen Harmony Care Center will continue to ensure 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. Nursing staff were re-educated on ADLs, the need to comply with resident/family preferences and how to receive that communication around preferences for the individual residents on 1/26/17. QA nurse to monitor for compliance with resident/family preferences with ADLS during her weekly rounds. Completion date 2/1/17	2/1/17

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During observation on 1/11/17, at 10:42 a.m., nursing assistant (NA)-A assisted R24 with getting dressed. NA-A picked out a pink sweater and a pair of jeans from R24's closet and asked R24 if she wanted to wear the clothes. NA-A dressed R24 in the clothes. As R24 was being moved to the dining room by NA-A R24 stated to NA-A, "I just do not want to be cold all the time." NA-A responded and asked R24 do you want another sweater? NA-A then went back to R24's room, obtained a blue cape and placed the blue cape over R24's shoulders.

During observation on 1/11/17, at 1:52 p.m., R24 was sitting in the living area in her wheelchair. FM-B approached R24 and greeted R24. FM-B then stated to R24, "Why don't you have a t-shirt on?" FM-B then approached a staff person and asked for R24 to have a t-shirt put on. At 1:54 p.m., surveyor asked R24 if she was cold and R24 replied, "I am a little cold."

On 1/11/17, at 2:15 p.m., social worker (SW)-A stated she had just heard FM-B tell a nursing assistant he would like a t-shirt put on R24. SW-A (when queried if staff were aware R24 was to have a t-shirt on) stated R24 was to have a t-shirt on under clothes and this is communicated in the Huddle Book. The nurse manager had written the information in the Huddle Book on 1/5/17, when R24's care conference was held.

The facility Huddle Book sheet dated 1/5/17, identified changes in plan of care, condition, medications, other: R24 "always" have a t-shirt on under sweatshirt or sweater per family request.

On 1/11/17, at 11:21 a.m., NA-A stated R24 does complain about being cold a lot. NA-A stated R24

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F 312	Continued From page 7 generally wears sweaters and we put the blue sweater (cape) over her shoulders. When queried if R24 had any t-shirts in her room to wear, NA-A showed surveyor R24 had t-shirt hanging in her closet for use. NA-A stated she was not aware R24 was to have a t-shirt on. I knew R24 had t-shirts, but was not aware she wanted a t-shirt on every day. On 1/12/17, at 1:00 p.m., the director of nursing (DON) stated communication huddles for staff were held at certain times throughout the day. If staff are not present during the huddle they are supposed to read the huddle communication book daily. The DON stated she would expect a t-shirt to be put on R24 when dressed as written in the huddle communication book. The facility policy Dressing and Undressing the Resident, dated revised 10/2010, indicated General Guidelines 2. Encourage the resident to choose the clothes that he or she will wear for the day.	F 312		
F 334 SS=D	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31	F 334		2/1/17

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annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;

(iii) The resident or the resident's representative has the opportunity to refuse immunization; and

(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:

(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and

(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-

(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;

(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;

(iii) The resident or the resident's representative has the opportunity to refuse immunization; and

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F 334	Continued From page 9 (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure documentation of education provided and documentation of consent for refusal signed by the resident or the resident representative for the influenza vaccination for 2 of 5 residents (R14 and R37) reviewed for immunizations. Findings include: On 1/11/17, surveyor had requested form the director of nursing R14's and R37's documented education provided and consent for administration of the influenza immunization. On 1/12/17, the following was provided by registered nurse (RN)-A: R14's Screening Questionnaire for Inactivated Injectable Influenza Vaccination was signed by the director of nursing on 10/31/16. The questionnaire failed to be filled out and failed to be signed by the resident or the resident representative. In addition, the questionnaire failed to address if education about the influenza vaccination was provided and failed to address if R14 consented to the administration of the influenza vaccination.	F 334	F334 Gundersen Harmony Care Center will continue to ensure that each resident or resident□s representative receives education regarding the benefits and potential side effects of an immunization prior to receiving or refusing the immunization. The influenza policy has been updated to reflect the need to document that the required education was given and consent or refusal of the influenza vaccination received is maintained in the resident□s health record. The influenza consent form was updated as well to align with this policy. QA nurse to monitor weekly that influenza policy is followed for all new admissions throughout the flu season. Completion date 2/1/17.	

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F 334	Continued From page 10 R37's Screening Questionnaire for Inactivated Injectable Influenza Vaccination was signed by the director of nursing on 10/31/16. The questionnaire failed to indicate yes or no to the question is the person to be vaccinated sick today. The questionnaire failed to be signed by the resident or the resident representative. In addition, the questionnaire failed to address if education about the influenza vaccination was provided and failed to address if R37 consented to the administration of the influenza vaccination. During interview on 1/12/17, at 2:28 p.m., RN-A stated routinely verbal consent whether to administer the influenza vaccine or not was obtained by phone from the resident representative or by talking to the resident. RN-A stated she did not know if education about the influenza vaccine was provided. RN-A stated I do not have documentation education for the influenza vaccination was provided to R14 and R37 and I do not have documentation of consent for administration or refusal of the influenza vaccination for R14 and R37. The facility policy Influenza, Prevention and Control, dated revised 10/2010, indicated Seasonal Influenza Vaccine 1. The Infection Control Coordinator will promote and administer seasonal influenza vaccine. a. Unless contraindicated, all residents and staff will be offered the vaccine. The policy failed to address documentation education was provided for the influenza vaccination and documented consent of administration or refusal for the influenza vaccination was maintained in the resident record as required.	F 334		

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F 441	Continued From page 11	F 441		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to:	F 441		2/1/17

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F 441	Continued From page 12 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper infection control practices were used during the provision of peri-cares for 1 of 3 residents (R24) reviewed for activities of daily living. Findings include: R24 had been observed on 1/11/17, at 10:42 a.m., when nursing assistant (NA)-A assisted R24	F 441	F441 Gundersen Harmony Care Center will continue to ensure that proper infection control practices will be used during provision with peri-cares for residents. Nursing staff were re-educated on the proper procedure for peri-cares on 1/26/17 by the Director of Nursing. QA nurse to monitor peri-care procedure weekly. Completion date 2/1/17.	

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F 441	Continued From page 13	F 441		

with dressed. NA-A washed hands and donned gloves. NA-A had washed R24's front peri area and without changing soiled gloves NA-A assisted R24 to roll over, applied lotion to R24's back, cleansed R24's buttocks area, placed a clean incontinent product underneath R24, then completed dressing R24 before removing the soiled gloves.

On 1/11/17, at 11:21 a.m., NA-A verified not changing soiled gloves when they should have.

On 1/12/17, at 2:28 p.m., registered nurse (RN)-A stated after providing peri-cares staff should remove gloves and wash hands before touching anything else.

On 1/12/17, at 1:00 p.m., the director of nursing (DON) stated staff should remove gloves and wash hands after providing peri-cares.

The facility policy Perineal Care, dated revised 10/2010, indicated Steps in Procedure 7. Put on gloves. 9. b. Wash perineal area wiping front to back. e. Wash the rectal area thoroughly 11. Discard disposable items into designated containers. 12. Remove gloves and discard into designated container. Wash and dry your hands thoroughly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245528	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**01/12/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUNDERSEN HARMONY CARE CENTER	**815 MAIN AVENUE SOUTH HARMONY, MN 55939**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Gundersen Harmony) was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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 By email to: Marian.Whitney@state.mn.us and	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/31/2017

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

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K 000	Continued From page 1 Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 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. The GUNDERSEN HARMONY CARE CENTER is a 1-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1963 and was determined to be of Type II(111) construction. In 1967, addition was constructed and was determined to be of Type II(111) construction. Because the original building and the 1 addition are of the same type of construction allowed for existing buildings, the facility was surveyed as one building. The facility is fully fire sprinklered. The facility has a fire alarm system with full corridor smoke detection, spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 43 beds and had a census of 30 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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	245528	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**01/12/2017**

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K 923 SS=D	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is not met as evidenced by:	K 923		1/23/17

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K 923	Continued From page 3 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) Findings Include: On facility tour between 09:00 AM and 01:00 PM	K 923	K923 Gundersen Harmony Care Center will continue to ensure that gas equipment-cylinder and container will be stored in an area greater than or equal to 3,000 cubic feet. This location will be designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. The corrosive cleaning supplies were removed from the oxygen storage room on 1/23/17. Housekeeping supervisor was re-educated on need to not store any corrosive cleaning supplies in the oxygen storage room. QA nurse to monitor O2 storage rooms weekly to ensure compliance. Completion date 1/23/17.	

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K 923	Continued From page 4 on 1/12/2017, based on observation and interview revealed that the following include: 1. Corrosive cleaning supplies were found in same room as O2 oxygen tanks located by room 103. They would need to be separated by 5 feet. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 923		

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted
January 23, 2017

Ms. Michelle Borreson, Administrator
Gundersen Harmony Care Center
815 Main Avenue South
Harmony, MN 55939

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5528027

Dear Ms. Borreson:

The above facility was surveyed on January 10, 2017 through January 12, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Gary Nederhoff, Unit Supervisor at (507) 206-2731.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00125	A. BUILDING: _____ B. WING _____	01/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUNDERSEN HARMONY CARE CENTER	815 MAIN AVENUE SOUTH HARMONY, MN 55939

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On January 10, 11, & 12, 2017, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to revise the care plan for 1 of 3 residents (R2) related to missing teeth, who was reviewed for dental status and failed to develop a plan of care that included monitoring for side effects of an anti-coagulant medication (Warfarin) for 1 of 5 residents (R24) reviewed for unnecessary medications. Findings include: R2's care plan last reviewed/revised dated 9/16/16, identified dental care problem and has own teeth. Denies problems with dentition. Approach: assist setting up dental visit if should	2 570	-	2/1/17

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2 570	Continued From page 3 request this. Provide supplies for oral care. Set up and assist as needed for oral care. However, R2's care plan failed to identify R2 had missing teeth. On 1/10/17, at 2:07 p.m., observation of R2's teeth, identified R2 had missing teeth on the bottom gum line. R2 stated she had missing teeth on the top and bottom. R2's facility Oral Health Assessment, observation/date recorded date, 11/30/16, identified condition of teeth none of the above were present. Plan of care: continue current plan of care, denies problems with chewing, says she eats mostly soft foods. On 1/12/17, at 12:56 p.m., the director of nursing (DON) stated she would expect the facility oral assessment to identify missing teeth and missing teeth to be care planned if identified. LACK OF CARE PLANNING INTERVENTIONS ADDRESSING USE OF ANTICOAGULATION THERAPY: R24's current physician order's identified an order for Warfarin, start date 1/6/17, two milligrams (mg) on Sunday, Monday, Tuesday, Wednesday, Thursday and Saturday and 1 mg on Friday for diagnoses of pulmonary embolism and embolism and thrombosis of arteries of the lower extremities. R24's Medication Administration Record dated 1/1/17 through 1/12/17, identified R24 was receiving the medication as ordered. R24's care plan, dated last reviewed/revised: 1/2/17, problem: has diagnoses of history of pulmonary embolus, DVT (deep vein thrombosis), osteoporosis, dementia with psychosis, history of	2 570		

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2 570	Continued From page 4 kidney failure, ankylyzing spondilosis. Approach: administer medications per provider's orders. Nursing staff will dispense and administer all medications. Monitor condition routinely by vital signs and weights per facility protocol. Obtain consults PRN (as needed). Obtain scheduled labs per provider's orders. Problem last reviewed/revised: 1/2/17: uses PPI (proton pump inhibitor) for diagnosis of history of gastric ulcer and use of anticoagulant due to history of pulmonary embolism and DVT. Approach: Consider an attempt gradual dose reduction of PPI. If already on lowest scheduled dose, consider changing PPI to PRN prior to discontinuation and monitor symptoms and the use of PRN PPI use. Consult with dietary department to determine what foods may trigger increased symptoms of GERD (Gastroesophageal reflux disease) and reduce the frequency of foods in diet or avoid them completely. Encourage resident to remain upright for at least 30 minutes after meals. Request pharmacy consultant review medications to determine if other medications are on regime that could make dyspepsia symptoms worse. Consider alternative medications if possible. However, R24's care plan had not addressed risk factors and interventions for excessive bleeding associated with the use of Warfarin in order to alert care givers the need to report bruising and bleeding timely to the nurse. On 1/12/17, at 12:57 p.m., the DON confirmed R24's care plan failed to include risk factors and interventions associated with the use of Warfarin. The facility policy Resident Care Plan, dated 11/26/16, indicated resident care plan documentation and use of the plan 5. The	2 570		

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2 570	Continued From page 5 resident care plan must be kept current at all times. Concerns and problems Problem 2. Consider listing possible risks and complications. Approach/Plan 1. List all care to be provided for the problem listed. The care must be necessary and appropriate to accomplish the goal stated. 2. Coordinate all care to be provided to the resident for the most effective, efficient utilization of resources 3. Individualized care for the unique needs of the resident 4. Communicate vital information to all staff providing direct resident care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan revisions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan revisions. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
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:	2 920		2/1/17

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2 920	Continued From page 6 Based on observation, interview and document review, the facility failed to apply a t-shirt or offer the use of a t-shirt during assist with dressing for 1 of 3 residents (R24) reviewed for activities of daily living. Findings include: R24's annual Minimum Data Set (MDS), dated 9/29/16, identified R24 required extensive assist of one for dressing and had moderate cognitive impairment. During interview of family member (FM)-B on 1/10/17, at 4:29 p.m., when asked does R24 get the help she needs getting dressed, toileting, or cleaning her teeth? FM-B had stated they (the staff) do not put enough clothes on her when she is dressed. She needs a t-shirt on, I brought some t-shirts for her to use. During observation on 1/11/17, at 10:42 a.m., nursing assistant (NA)-A assisted R24 with getting dressed. NA-A picked out a pink sweater and a pair of jeans from R24's closet and asked R24 if she wanted to wear the clothes. NA-A dressed R24 in the clothes. As R24 was being moved to the dining room by NA-A R24 stated to NA-A, "I just do not want to be cold all the time." NA-A responded and asked R24 do you want another sweater? NA-A then went back to R24's room, obtained a blue cape and placed the blue cape over R24's shoulders. During observation on 1/11/17, at 1:52 p.m., R24 was sitting in the living area in her wheelchair. FM-B approached R24 and greeted R24. FM-B then stated to R24, "Why don't you have a t-shirt on?" FM-B then approached a staff person and asked for R24 to have a t-shirt put on. At 1:54	2 920	-	

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2 920	Continued From page 7 p.m., surveyor asked R24 if she was cold and R24 replied, "I am a little cold." On 1/11/17, at 2:15 p.m., social worker (SW)-A stated she had just heard FM-B tell a nursing assistant he would like a t-shirt put on R24. SW-A (when queried if staff were aware R24 was to have a t-shirt on) stated R24 was to have a t-shirt on under clothes and this is communicated in the Huddle Book. The nurse manager had written the information in the Huddle Book on 1/5/17, when R24's care conference was held. The facility Huddle Book sheet dated 1/5/17, identified changes in plan of care, condition, medications, other: R24 "always" have a t-shirt on under sweatshirt or sweater per family request. On 1/11/17, at 11:21 a.m., NA-A stated R24 does complain about being cold a lot. NA-A stated R24 generally wears sweaters and we put the blue sweater (cape) over her shoulders. When queried if R24 had any t-shirts in her room to wear, NA-A showed surveyor R24 had t-shirt hanging in her closet for use. NA-A stated she was not aware R24 was to have a t-shirt on. I knew R24 had t-shirts, but was not aware she wanted a t-shirt on every day. On 1/12/17, at 1:00 p.m., the director of nursing (DON) stated communication huddles for staff were held at certain times throughout the day. If staff are not present during the huddle they are supposed to read the huddle communication book daily. The DON stated she would expect a t-shirt to be put on R24 when dressed as written in the huddle communication book. The facility policy Dressing and Undressing the Resident, dated revised 10/2010, indicated	2 920		

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2 920	Continued From page 8 General Guidelines 2. Encourage the resident to choose the clothes that he or she will wear for the day. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could provide training for all nursing staff related to providing activities of daily living (ADL's). The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		2/1/17

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21426	Continued From page 9 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 5 of 5 employees (E-A, E-B, E-C, E-D and E-E) had a Tuberculosis (TB) symptom screen completed; failed to ensure 2 of 5 employees (E-B and E-D) had first and second step tuberculosis skin test (TST) completed; failed to ensure 4 of 5 employees (E-A, E-C, E-D, and E-E) two step TST's included the times of administration, times of read results, and induration and negative/positive readings; failed to ensure 5 of 5 residents (R37, R38, R40, R34 and R14) had a TB symptom screen completed; failed to ensure 1 of 5 residents (R34) had a two-step TST completed; failed to ensure 5 of 5 residents (R37, R38, R40, R34 and R14) TST's read results included induration and negative/positive readings; and failed to ensure education for 2 of 5 employees (E-B and E-D) for TB was completed upon hire and all the facility employees had been educated for the facility TB infection control plan. This had the potential to affect all residents in the facility, staff and visitors. Findings include: EMPLOYEE TB SCREEN: E-A's New Employee Mantoux Questionnaire dated 4/5/16, E-C dated 6/14/16 and E-E dated 10/4/16 included the following information: 1. Have you ever had redness, swelling, or hardness as a result of a mantoux skin test? 2. Have you ever had a positive result and required a chest x-ray? 3. Have you ever had a BCG immunization against TB? 4. Do you have a protein or egg allergy? 5. Have you received any immunizations in the past month? 6. Are you	21426	-	

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21426	Continued From page 10 currently taking or have you taken immunosuppressive drugs or steroids? The facility New Employee Mantoux Questionnaire for E-A, E-C and E-E failed to include a screen for signs and symptoms of active TB, as required. In addition, E- B and E-D lacked a TB screen completed upon hire, as required. On 1/12/17, at 10:50 a.m., registered nurse (RN)-A stated that was all the information she had regarding TB screens for E-A, E-B, E-C, E-D and E-E. EMPLOYEE TB TST: E-B had a hire date of 6/14/16. E-B failed to have a first and second step TST upon hire as required. E-D had a hire date of 9/1/16. E-D had a first step TST completed on 9/1/16 and read on read on 9/3/16. E-D failed to have a second step TST completed as required. On 1/12/17, at 10:50 a.m., RN-A verified E-D and E-B lacked the two step TST. EMPLOYEE TST READ RESULTS: E-A had a first step TST on 4/5/16, read on 4/7/16, with results of induration of 0 millimeters (mm). Second TST on 4/13/16, read on 4/15/16, with results of induration of 0 mm. The first and second step TST's failed to include the reading of negative or positive as required. E-C had a first step TST on 6/14/16, read on	21426		

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21426	Continued From page 11 6/17/16 with negative results. The first step TST failed to include times of administration and reading to ensure the reading of the TST was read within the 48 to 72 hours as required and the TST results failed to include induration. E-D had a first step TST on 9/1/16, read on 9/3/16, results of induration of 0 mm. The results failed to include the reading of negative or positive as required. E-E had a first step TST on 10/4/16, read on 10/6/16, results of negative and "no bump." Second TST on 10/12/16, read on 10/15/16, with results of negative. The first and second step TST failed to include induration. In addition, the second step failed to include times of administration and reading to ensure the reading of the TST was read within the 48 to 72 hours as required. RESIDENT SCREEN: R37, R38, R40, R34 and R14 records were reviewed and did not contain documentation of a TB symptom screen was completed upon admission as required nor was it provided when requested by RN-A on 1/12/17 at 10:50 a.m. On 1/12/17, at 10:50 A.M., RN-A stated I do not have TB screens for the R37, R38, R40, R34 and R14. RN-A stated we (the facility) had not completing TB screens for residents. RESIDENT TST: R37 had a first step TST on 6/23/16, read on 6/25/16, with induration of 0 mm. Second step on 7/7/16 and read on 7/9/16, with induration of 0 mm. The first and second step TST's failed to include the reading of negative or positive as required.	21426		

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21426	Continued From page 12 R38 had a first step TST on 10/21/16, read on 10/23/16, with results of negative. Second step on 11/1/16 and read on 11/3/16, with results of negative. The results for the first and second step TST's failed to include induration. R40 had a first step TST on 11/14/16, read on 11/16/16, with results of 0. Second step on 11/24/16 and read on 11/27/16, with results of negative. The results for the first step TST lacked induration of mm and if negative or positive. The second step TST lacked induration. R34 lacked documented administration of a first step TST. Second step on 12/20/16 and read on 12/23/16, results negative. The second step TST lacked induration. R14 had a first step TST on 3/11/16, read on 3/13/16, with results of negative. Second step on 3/21/16 and read on 3/23/16, with results of negative. The first and second step TST's failed to include induration. On 1/12/17, at 10:50 a.m., RN-A verified the above. STAFF EDUCATION: E-B and E-D lacked documentation TB education had been completed. In addition, the facility failed to provide education regarding the facility TB infection control plan for all the facility employees. On 1/12/17, at 10:50 a.m., RN-A, confirmed E-B and E-D lacked TB education. RN-A confirmed the facility had not completed TB education with employees regarding the facility TB infection control plan. RN-C confirmed the TB education provided on the computer system failed to include	21426		

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21426	Continued From page 13 the facility TB infection control plan. The facility policy TB Screening Employee, dated 2010, indicated Policy I. Tuberculin Skin Test (TST): 1. New employees who present a written report of negative two-step TST within the previous 12 months will not need their TB screen retested and an employee screening tool will be completed. Education will be provided to new employee on reporting of new signs and symptoms as indicated on screening tool. However, the policy failed to address as per regulations for TB control in Minnesota health care settings dated 7/13, testing for the presence of infection with Mycobacterium TB by administering either a two-step TST or single IGRA (Interferon Gamma Release Assay) within 90 days of hire or upon hire and TB symptom screen at the time of hire as required. The facility policy TB Screening Residents, dated revised 7/13, indicated Screening New Admission or Readmissions: 1. The facility will screen referrals for admission and readmission for information regarding exposure to or symptoms of TB and will check results of recent (within 12 months) TST, blood assay for Mycobacterium tuberculosis (BMAT) or chest X-rays (CXR). However, the policy failed to address as per regulations for TB control in Minnesota health care settings dated 7/13, testing for the presence of infection with Mycobacterium TB by administering either a two-step TST or single IGRA (Interferon Gamma Release Assay) upon admission or within 90 days of admission and TB symptom screen upon admission as required. The facility policy Infection Control Program, dated 2010, indicated V. Responsibilities: 4. Training: a. Provide regular inservice training	21426		

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21426	Continued From page 14 programs to assure that all employees understand the importance of infection control and the role they play in preventing infections and transmission. b. Provide right to know training to assure personnel understand how to protect themselves from exposure to blood borne pathogens, tuberculosis, or other infectious diseases. SUGGESTED METHOD OF CORRECTION: The director of nursing could review tuberculosis policies and procedures to ensure compliance. The director of nursing could educate all employees regarding TB education and the facility infection control plan. The director of nursing could monitor compliance for screening and TST for employees and residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		