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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: D6AH
Facility ID: 00343

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245228**

2. STATE VENDOR OR MEDICAID NO. (L2) **019545601**

3. NAME AND ADDRESS OF FACILITY
(L3) **AVERA MORNINGSIDE HEIGHTS CARE CENTER**
(L4) **300 SOUTH BRUCE STREET**
(L5) **MARSHALL, MN** (L6) **56258**

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) **11/02/2009**

6. DATE OF SURVEY **02/02/2016** (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 **76** (L18)

13.Total Certified Beds **76** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	76			
(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 :
Tammy Williams, HFE NE II 03/01/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 04/7/2016 (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 **08/01/1979** (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): 245228

April 7, 2016

Ms. Doris Derynck, Administrator
Avera Morningside Heights Care Center
300 South Bruce Street
Marshall, MN 56258

Dear Ms. Derynck:

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 January 26, 2016 the above facility is certified for or recommended for:

76 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 76 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
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Protecting, maintaining and improving the health of all Minnesotans

2nd ALL CORRECTED-REVISED LETTER

Electronically delivered

February 29, 2016

Ms. Doris Derynck, Administrator
Avera Morningside Heights Care Center
300 South Bruce Street
Marshall, MN 56258

RE: Project Number S5228026 and Complaint Number H5228008

Dear Ms. Derynck:

On January 6, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective January 11, 2016. (42 CFR 488.422)

This was based on the deficiencies cited by the Department of Health, Office of Health Facility Complaints for an abbreviated standard survey completed on November 19, 2015, to investigate Complaint Number H5228008 and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on December 17, 2015. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On February 2, 2016, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on December 17, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 26, 2016. Based on our revisit, we have determined that your facility has obtained substantial compliance.

As a result of the revisit findings, the Department Has discontinued the Category 1 remedy of state monitoring effective January 26, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of January 6, 2016. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective February 19, 2016, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective February 19, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective February 19, 2016, is to be rescinded.

In our letter of January 6, 2016, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 19, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on January 26, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition.

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:

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
Email: Kathryn.serie@state.mn.us
Office: (507) 476-4233Fax: (507) 537-7194

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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would occur after the date you identified that compliance was achieved in your plan of correction.

Feel free to contact me if you have questions.

Sincerely,

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245228		2/2/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTER	300 SOUTH BRUCE STREET MARSHALL, MN 56258

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 F0166 Reg. # 483.10(f)(2) LSC	Correction Completed 01/26/2016	ID Prefix F0225 Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4) LSC	Correction Completed 01/26/2016	ID Prefix F0226 Reg. # 483.13(c) LSC	Correction Completed 01/26/2016
ID Prefix F0241 Reg. # 483.15(a) LSC	Correction Completed 01/26/2016	ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 01/26/2016	ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 01/26/2016
ID Prefix F0325 Reg. # 483.25(i) LSC	Correction Completed 01/26/2016	ID Prefix F0356 Reg. # 483.30(e) LSC	Correction Completed 01/26/2016	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 01/26/2016
ID Prefix F0465 Reg. # 483.70(h) LSC	Correction Completed 01/26/2016	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)	DATE	SIGNATURE OF SURVEYOR	DATE
	KS/kfd	2/26/2016	32603	2/2/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
12/17/2015

☐ 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245228 Y1	A. Building 02 - NEW BUILDING AND RENOVATED EXISTING BLD B. Wing Y2	2/11/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTER	300 SOUTH BRUCE STREET MARSHALL, MN 56258

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 K0029	Correction Completed 01/26/2016	ID Prefix Reg. # NFPA 101 LSC K0072	Correction Completed 01/26/2016	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 2/17/2016	SIGNATURE OF SURVEYOR 36536	DATE 2/11/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 12/16/2015	☐ 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

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: D6AH
Facility ID: 00343

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245228**

2.STATE VENDOR OR MEDICAID NO.
(L2) **019545601**

3. NAME AND ADDRESS OF FACILITY
(L3) **AVERA MORNINGSIDE HEIGHTS CARE CENTER**
(L4) **300 SOUTH BRUCE STREET**
(L5) **MARSHALL, MN** (L6) **56258**

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) **11/02/2009**

6. DATE OF SURVEY **12/17/2015** (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 **76** (L18)
13.Total Certified Beds **76** (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
	76			
(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 :
Pamela Manzke, HFE NE II 01/26/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 02/01/2016 (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
08/01/1979
(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

January 6, 2016
Electronically delivered

Ms. Doris Derynck, Administrator
Avera Morningside Heights Care Center
300 South Bruce Street
Marshall, MN 56258

RE: Project Number S5228026 and Complaint Number H5228008

Dear Ms. Derynck:

On December 4, 2015, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health, Office of Health Facility Complaints, 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 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 December 17, 2015, 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 standard survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that the facility has not achieved substantial compliance. This Department is imposing the following Category 1 remedy:

- State Monitoring effective January 11, 2016. (42 CFR 488.422)

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

Mandatory Denial of payment for new Medicare and Medicaid admissions effective February 19, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective February 19, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 19, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Based on the findings of the standard survey completed on December 17, 2015, we recommended to the CMS Region V Office the following additional remedy:

- Civil money penalty for deficiency at F309, effective December 17, 2015. (42 CFR 488.430 through 488.444)

Furthermore, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Avera Morningside Heights Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective February 19, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

APPEAL RIGHTS
If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Jan.Suzuki@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you

have any questions regarding this matter, please contact Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov .

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:

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
Email: Kathryn.serie@state.mn.us
Office: (507) 476-4233 Fax: (507) 537-7194

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,

- Include electronic acknowledgement 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 remedy be imposed:

- Optional Denial of payment for new Medicare and Medicaid admissions (42CFR 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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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 February 19, 2016 (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 May 19, 2016 (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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245228	A. BUILDING ______ B. WING ______	12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTER	300 SOUTH BRUCE STREET MARSHALL, MN 56258

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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 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to actively seek a resolution to voiced grievances for 1 of 1 resident (R88) in the sample whose family identified that staff call light response was not timely. Findings include: Review of R88's care plan dated 11/16/15, indicated an admit date of 2/11/15, with diagnoses including history of stroke with left sided hemiparesis (paralysis) and encephalopathy (disease, damage or malfunction	F 166	Plan of correction Disclaimer Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. This Plan of Correction is prepared and executed as a means for continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility's allegation of compliance.	1/26/16

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

Electronically Signed — 01/14/2016

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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F 166	Continued From page 1 of the brain). The care plan further indicated R88 did not speak English (only Spanish) though understood most English, was totally dependent on staff with transfers, bed mobility, personal hygiene, locomotion, and toileting, and could sometimes tell staff when "wet" (incontinent of urine) and needed to be changed. When interviewed on 12/17/15, at 8:39 a.m. family member (FM)-B voiced a concern that happened during "MEA" (Minnesota Education Association) weekend -October 2015. FM-B stated she visited R88 and spent the night with her in her room. FM-B reported that R88 activated her call light during the overnight shift (10 p.m.-6:00 a.m.) because she was "wet"; FM-B confirmed R88 wore an incontinent product as she was incontinent of urine. FM-B stated a short time after R88 put her call light on, it was turned off by staff; but no staff came to the room to respond to the need for assistance. FM-B stated R88 then reactivated the call light a second time but again it was immediately turned off, without staff coming to the room to respond. FM-B stated after she instructed R88 to put the call light "on" a third time, staff eventually responded over the intercom into R88's room, stating they would "be there in a little bit". However, staff still did not respond and come to the room to provide assistance. FM-B stated she waited a few minutes longer and then checked the hallway outside R88's room to see if additional resident call lights were "on". When she observed that none were "on", FM-B proceeded to walk down the hallway to locate staff. As a staff member walked around the corner, FM-B said, "The staff member's face just fell." FM-B stated she reported this incident to the licensed social worker (LSW).	F 166	Facility became aware of incident during the December care conference. Initial incident had occurred in October. Social worker encouraged family members to bring forward concerns as soon as possible. Interviewed staff assigned to work on 10/18/15 and discussed family concerns and expectations concerning answering call lights. Unable to determine specific staff person involved. Facility social worker contacted residents daughter via phone calls and emails to discuss incident and discuss follow up with staff. Education provided to staff concerning the answering of call lights at the December staff meetings. Ongoing Compliance: Facility policy on Grievances updated and reviewed with staff at all staff meetings on 1/20/16. Facility managers will develop a grievance log which wi8ll contain grievances brought forward by residents and families. Grievance logs will be monitored by DON for compliance with facility policy, results reported to the LTC quality monthly x3 months, quarterly thereafter. Staff re-educated on facility policy regarding answering resident call lights, education and policy included answering all call lights in resident rooms. Staff meetings occurred on January 21, 2016. On-going compliance: Visual monitoring of staff answering resident call lights in the resident room(s) and responding to residents need(s) at the time the resident call light is put on will occur, monthly x3 months, quarterly thereafter and reported to LTC Quality	

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F 166	Continued From page 2 Review of the care conference notes dated 11/19/15, under "Family Comments" indicated: "concern that call light was turned off when family stayed during the night X 3, no one came into the room....[social worker first name] will follow up with this". Review of the Care Conference Summary Sheet dated 11/19/15 included: "follow up with [family member first name] regarding MEA incident." Review of an email dated 12/3/15, at 11:20 a.m. from FM-B to LSW included: "Regarding the incident over MEA the night I stayed over was on October 15th, 2015. When my mom had called for assistance was at about 11:45 p.m.-12 a.m." When interviewed on 12/17/15, at 11:35 a.m. the LSW confirmed FM-B had voiced concerns related to (r/t) the evening of 10/15/15, and the lack of call light response for R88. The LSW further stated FM-B did not bring it to the facility's attention until R88's care conference dated 11/19/15, and stated the facility had conducted an investigation and subsequently provided education to all staff at the December 2015 staff meeting. She acknowledged staff had been educated r/t call light responses, and had been given the direction to only cancel call lights from a resident's room and not at the nurses' station. The LSW could not provide any specific date the education had been provided to direct care staff and confirmed the facility didn't really have a formal process r/t grievances other than some handwritten notes taken in a spiral notebook. When interviewed on 12/17/15, at 12:25 p.m. the director of nursing (DON) stated staff had been	F 166	committee.	

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F 166	Continued From page 3 educated on the call light system, including that call lights were supposed to be canceled in the resident's rooms and not at the desk. R88's call light logs for the evening of 10/15/15 and early morning of 10/16/15 were requested from the facility but were not provided.	F 166		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported	F 225		1/26/16

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F 225	Continued From page 4 to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report potential abuse/neglect/mistreatment to the administraotr and the State Agency (SA) for 2 of 4 residents (R128, R96) reviewed for abuse prohibition. Findings include: R128's face sheet, identified R128 was admitted to the facility 4/9/15. R128's hospital discharge summary included diagnoses of left hip fracture, acute hypoxemic respiratory failure, altered mental status and pneumonia. An incident report of an allegation of neglect for R128 was submitted to the SA on 4/13/15 and revealed, "Resident was admitted from Avera McKennan hospital on 4/9/15. On the morning of 4/10/15, staff nurse entered room and found resident to be lethargic, bi-pap at bedside was not on. Resident 02 SATs [oxygen saturation level] at that time were 65% and patient was responsive to stimuli only. Physician here and transferred to ER for further treatment." The investigative report dated 4/17/15, revealed, "Discussion held with nursing staff who admitted resident on 4/9/15. It was verbally reported from Avera Mckennan nurse that the resident was to wear a Bi-pap with oxygen at night. This was reported on to the night nurse by both the charge	F 225	Action plan created. Action plan items include: updating the Vulnerable Adult policy to include situations that must be immediately reported. The update includes the need to report immediately if the resident has an injury and the resident is unable to explain what happened. Update also includes update on who incidents should be immediately reported to. Education to staff on new policy requirements at January 20, 2016 staff meetings. Education will be provided as part of new employee orientation and annually for all employees. All registered nurses will be provided education and complete a competency on immediate reporting of incidents. Process map developed on process for reporting VA incidents. Ongoing compliance: Audit tool developed to track all incidence of VA reports including any needed follow up. Nurse managers will review all quality monitors on a daily basis to review for any suspected vulnerable adult concerns.	

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F 225	Continued From page 5 nurse as well as the unit LPN from the shift. Residents [sic] wife brought the bi-pap in from home to be utilized and the machine was present at bedside. Discussed with nurse who worked the night shift in regards to the use of the bi-pap and he confirmed that he was not given the report that the resident was to use bi-pap and the bi-pap was available but he did not place it on the resident during his shift. There were no vital signs documented per protocol for this resident and scheduled neb [nebulizer] treatment was not administered in a timely manner by the nurse providing care. Disciplinary action has been completed with this employee leading to termination of employment for failure to follow the plan of care for this resident. The resident was transferred to Sioux Falls after the ER [emergency room] visit on the morning of 4/10/15 and admitted to their hospital for further care. Expectation of all staff is to read and understand the plan of care for the residents which they are responsible to provide care for." On 12/17/2015 10:51 a.m. the director of nursing (DON) stated 4/10/15 was a Friday and originally the staff working that day did not feel it was a reportable incident. The DON stated R128 was found with low oxygen saturation in the morning, the bi-pap was not on and stated staff responded immediately by sending him to the emergency room for an evaluation. The DON stated it was morning time and R128 would not necessarily have needed to have the bi-pap machine on at the time it was discovered by staff. The DON stated I feel like the staff responded appropriately at the time of the incident by sending him to the emergency room. The DON stated that through her investigation on 4/13/15, it was determined that bi-pap was not used for R128 the night of 4/9/15 and she filed the report to the SA. The	F 225		

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F 225	Continued From page 6 DON stated she was unable to conclude whether or not having the bi-pap machine caused the low oxygen saturation due to R128's condition. The DON stated she filed the report to the SA as soon as she realized the nurse had not followed the care plan for R128. The DON stated, "I do not think there was a very good immediate investigation of what happened on 4/9/15 to determine whether R128 had used the bi-pap." The DON verified the incident occurred on 4/10/15 and the report had not been made to the SA until 4/13/15. The DON verified the incident should have been immediately reported to the SA on 4/10/15. R96's face sheet, identified R96 was admitted to the facility from the adjoining assisted living on 6/23/15. The diagnosis summary list included, aftercare healing traumatic fracture of vertebrae, senile dementia and giant cell arteritis. An incident report for an injury of unknown source for R96 was submitted to the SA on 7/16/15 (5 days post occurrence). The report indicated: "Date incident occurred: 7/11/15. Resident self transferred to the bathroom. Staff found resident on the floor in bathroom doorway. Resident complaining of hip pain, xrays ordered at the time of fall revealed fracture. Per MD orders resident resided in nursing home until surgeon could evaluate in the morning." The investigative report dated 7/21/15, identified: "Root cause analysis completed with nursing team along with quality department to investigate fall that occurred on 7/11/15. No signs of inappropriate activity and care plan was followed up to and after events leading to fall. Resident was transported the following morning 7/12/15, to the hospital when surgeon was available to	F 225		

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F 225	Continued From page 7 evaluate for hip fracture. Family discussed surgery vs. comfort measures. Surgery performed to provide resident with comfort, prognosis poor post surgery. Surgery completed on 7/13/15, was transferred back to LTC (long term care) on 7/15/15 and resident expired on 7/16/15. On 12/17/2015, at 9:28 a.m. the director of nursing (DON) stated, "all I can think of for why it was not reported until the 16th is maybe it was a weekend. It should have been reported earlier. Staff was following the care plan for falls. A report should have been filed right away. The charge nurse would call and let the Vice President (VP) and myself know and then the charge nurse should have filed the initial complaint. Myself or administrator should have been called immediately. I doubt it was done. The staff was re-educated on the procedure. I don't remember. A fall with injury should have been reported immediately." The DON stated she filed the report to the SA when the resident returned from the hospital 7/16/15, but verified the incident had occurred on 7/11/15. The Vulnerable Adult Abuse prevention Plan policy last revised 6/15 specified, "...Internal reports: Staff members who have knowledge of any incident involving maltreatment of a VA[vulnerable adult] must make an immediate (example of immediate: upon witness of incident or immediately following the incident) report to the designated Administrative staff: Appropriate Vice President, Department Manager, CEO, departments charge nurse (House Charge/Team Leader)...Staff will investigate the incident and determine if a report should be filed with Adult/Protection/Common Entry Point (CEP). All	F 225		

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F 225	Continued From page 8 persons on/in area of incident must be interviewed at this time of the incident occurrence. If a report should be filed with the CEP, the report will be made immediately, upon knowledge of the incident. LTC/Swing Bed providers will make reports to MDH (Minnesota Department of Health) via the secure web site in a two step process."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow the Abusive Adult Abuse Prevention Plan to immediately report potential abuse/neglect/mistreatment to the State Agency (SA) and administrator for 2 of 4 residents (R96, R128) reviewed for abuse prohibition. Findings include: The Vulnerable Adult Abuse prevention Plan policy last revised 6/15 specified, "...Internal reports: Staff members who have knowledge of any incident involving maltreatment of a VA[vulnerable adult] must make an immediate (example of immediate: upon witness of incident or immediately following the incident) report to the designated Administrative staff: Appropriate Vice President, Department Manager, CEO, departments charge nurse (House Charge/Team	F 226	Action taken to address incident/problem: The Vulnerable Adult policy updated to include situations that must be immediately reported. The policy update includes the need to report immediately if the resident has an injury and the resident is unable to explain what has happened. Education provided to current staff at January 21, 2016 all staff meeting(s). On-going compliance: Vulnerable Adult Policy Education will be provided as part of new employee orientation and annually for all employees. All registered nurses will be provided education and complete a competency on how to report VA incidents. Process map tool developed for staff to utilize when incidents occur as a guide to reporting incidents and reviewed	1/26/16

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F 226	Continued From page 9 Leader)...Staff will investigate the incident and determine if a report should be filed with Adult/Protection/Common Entry Point (CEP). All persons on/in area of incident must be interviewed at this time of the incident occurrence. If a report should be filed with the CEP, the report will be made immediately, upon knowledge of the incident. LTC/Swing Bed providers will make reports to MDH (Minnesota Department of Health) via the secure web site in a two step process." R128's face sheet, identified R128 was admitted to the facility 4/9/15. R128's hospital discharge summary included diagnoses of left hip fracture, acute hypoxemic respiratory failure, altered mental status and pneumonia. An incident report of an allegation of neglect for R128 was submitted to the SA on 4/13/15 and revealed, "Resident was admitted from Avera McKennan hospital on 4/9/15. On the morning of 4/10/15, staff nurse entered room and found resident to be lethargic, bi-pap at bedside was not on. Resident 02 SATs [oxygen saturation level] at that time were 65% and patient was responsive to stimuli only. Physician here and transferred to ER for further treatment." The investigative report dated 4/17/15, revealed, "Discussion held with nursing staff who admitted resident on 4/9/15. It was verbally reported from Avera Mckennan nurse that the resident was to wear a Bi-pap with oxygen at night. This was reported on to the night nurse by both the charge nurse as well as the unit LPN from the shift. Residents [sic] wife brought the bi-pap in from home to be utilized and the machine was present at bedside. Discussed with nurse who worked the night shift in regards to the use of the bi-pap and he confirmed that he was not given the report that	F 226	with staff at January 21, 2016 all staff meetings. Nurse Managers will be reviewing resident incident reports on a daily basis to assure all required VA incidents have been reported as required. An audit tool developed to track all incidence of VA reports including any needed for follow up, all VA reports will be reported to LTC Quality Committee on a monthly basis.	

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AVERA MORNINGSIDE HEIGHTS CARE CENTER	**300 SOUTH BRUCE STREET MARSHALL, MN 56258**

(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 226	Continued From page 10 the resident was to use bi-pap and the bi-pap was available but he did not place it on the resident during his shift. There were no vital signs documented per protocol for this resident and scheduled neb [nebulizer] treatment was not administered in a timely manner by the nurse providing care. Disciplinary action has been completed with this employee leading to termination of employment for failure to follow the plan of care for this resident. The resident was transferred to Sioux Falls after the ER [emergency room] visit on the morning of 4/10/15 and admitted to their hospital for further care. Expectation of all staff is to read and understand the plan of care for the residents which they are responsible to provide care for." On 12/17/2015 10:51 a.m. the director of nursing (DON) stated 4/10/15 was a Friday and originally the staff working that day did not feel it was a reportable incident. The DON stated R128 was found with low oxygen saturation in the morning, the bi-pap was not on and stated staff responded immediately by sending him to the emergency room for an evaluation. The DON stated it was morning time and R128 would not necessarily have needed to have the bi-pap machine on at the time it was discovered by staff. The DON stated I feel like the staff responded appropriately at the time of the incident by sending him to the emergency room. The DON stated that through her investigation on 4/13/15, it was determined that bi-pap was not used for R128 the night of 4/9/15 and she filed the report to the SA. The DON stated she was unable to conclude whether or not having the bi-pap machine caused the low oxygen saturation due to R128's condition. The DON stated she filed the report to the SA as soon as realized the nurse did not follow the care plan for R128. The DON stated I do not think there	F 226		

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F 226	Continued From page 11 was a very good immediate investigation of what happened on 4/9/15 to determine whether R128 had used the bi-pap. The DON verified the incident occurred on 4/10/15 and the report was not made to the SA until 4/13/15. The DON verified an incident report should have been made immediately reported to the SA on 4/10/15. On 12/17/2015 11:14 a.m. the DON verified the facility did follow the Vulnerable Adult Abuse prevention Plan policy to report immediately to SA. R96's face sheet, identified R96 was admitted to the facility from the adjoining assisted living on 6/23/15. The diagnosis summary list included, aftercare healing traumatic fracture of vertebrae, senile dementia and giant cell arteritis. An incident report of an injuries of unknown source for R96 was submitted to the SA on 7/16/15 (5 days post occurrence) and revealed, "Date incident occurred: 7/11/15. "Resident self transferred to the bathroom. Staff found resident on the floor in bathroom doorway. Resident complaining of hip pain, rays ordered at the time of fall revealed fracture. Per MD orders resident resided in nursing home until surgeon could evaluate in the morning." The investigative report dated 7/21/15, identified "Root cause analysis completed with nursing team along with quality department to investigate fall that occurred on 7/11/15. No signs of inappropriate activity and care plan was followed up to and after events leading to fall. Resident was transported the following morning, 7/12/15 to the hospital when surgeon was available to evaluate for hip fracture. Family discussed surgery vs. comfort measures. Surgery	F 226		

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F 226	Continued From page 12 performed to provide resident with comfort, prognosis poor post surgery. Surgery completed on 7/13/15, was transferred back to LTC on 7/15/15 and resident expired on 7/16/15. On 12/17/2015, at 9:28 a.m. the director of nursing (DON) stated, "all I can think of is why it was not reported until the 16th is maybe it was a weekend. It should have been reported earlier. Staff was following the care plan for falls. A report should have been filed right away. The charge nurse would call and let the Vice President (VP) and myself know and then the charge nurse should have filed the initial complaint. Myself or administrator should have been called immediately. I doubt it was done. The staff was re-educated on the procedure. I don't remember. A fall with injury should have been reported immediately." The DON stated she filed the report to the SA when the resident returned from the hospital and verified the incident occurred on 7/11/15, but was not reported to the SA until 7/16/15, not immediately.	F 226		
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 ensure 1 of 3 residents (R50) reviewed for dignity received assistance with haircare as per her customary preferences.	F 241	Interviewed residents family to determine when family would like hair fixed and included this into the residents plan of care.	1/26/16

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F 241	Continued From page 13 Findings include: R50's diagnoses, according to physican's progress notes dated 12/1/15, included end-stage dementia. R50's Annual Minimum Data Set (MDS), dated 10/18/15 indicated R50 required extensive assistance of two staff for grooming. The MDS indicated R50 was rarely or never understood and had short and long-term memory loss. A Care Area Assessment (CAA) for activities of daily living (ADL) did not trigger with this assessment. R50's care plan, dated 2/16/12 and provided by the facility as the most current copy, indicated she was total assistance of one staff for bathing and required assist of one to two staff for grooming. No preferences related to hair care were identified on the care plan. During interview on 12/15/15, at 10:14 a.m., family (FM)-A stated R50 gets her hair washed every Monday with her bath early in the a.m. before breakfast "then it stays unkempt until 3 p.m. when she goes to beauty shop." This would have really bothered R50 as she was a "very sophisticated woman," and liked to be well-groomed with set hair and had worked as a hospital receptionist. FM-A felt this was undignified and stated, "Just because her condition has declined does not make it o.k." During observation on 12/16/15, at 7:30 a.m., R50 was resting in bed sleeping. At 8:43 a.m., nursing assistant (NA)-B got R50 up for the day. On 12/16/15, at 9:07 a.m., NA-B stated R50's hair	F 241	Ongoing compliance: Developed policy on resident quality of life which will be reviewed at January 20, 2016 staff meetings. Develop quality monitoring tool to monitor for quality of life requirements. Quality of life preferences added to residents welcome to notice which all staff receive when resident is admitted. Monitoring will be reported to LTC quality monthly x3 and quarterly thereafter.	

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F 241	Continued From page 14 was washed on Mondays prior to breakfast, but sometimes did not get done until afternoon because things were "hectic on the unit." R50 generally was done with her bath around 8:30 a.m. NA-B reported she was aware FM-A wanted to make sure it looked nice. During further interview on 12/16/15, at 9:20 a.m. FM-A stated she had complained about R50's hair not getting done in a timely manner after her bath and had complained to the charge nurse on duty on several occasions. FM-A stated the response she got was that they would "get at it," and it just "depends on who the aide for the day is whether it gets done or not." During interview on 12/16/15, at 11:49 a.m. registered nurse (RN)-A, who was R50's unit nurse manager stated she had not been aware FM-A had concerns about her hair not being set, but there was "No reason why staff couldn't set [R50's] hair right after breakfast."	F 241		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure necessary nursing care	F 309	DON appraised of situation on 4/10/15. Staff working night shift on 4/10/15	1/26/16

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F 309	Continued From page 15 and services were provided for 1 of 1 resident (R128) reviewed with a history of acute respiratory failure and pneumonia. This resulted in actual harm for R128, who required emergency room (ER) care at the local critical access hospital (CAH) and subsequent transfer and admission to an acute care hospital. Findings include: R128's face sheet, identified R128 was admitted to the facility 4/9/15. R128's hospital discharge summary included diagnoses of left hip fracture, acute hypoxemic respiratory failure, altered mental status and pneumonia. An incident report related to an allegation of neglect for R128 had been submitted by the facility to the State Agency (SA) on 4/13/15 which indicated, "Resident was admitted from Avera McKennan hospital on 4/9/15. On the morning of 4/10/15, staff nurse entered room and found resident to be lethargic, bi-pap at bedside was not on. Resident 02 SATs [oxygen saturation level] at that time were 65% and patient was responsive to stimuli only. Physician here and transferred to ER for further treatment." The facility's investigative report dated 4/17/15 included: "Discussion held with nursing staff who admitted resident on 4/9/15. It was verbally reported from Avera Mckennan nurse that the resident was to wear a Bi-pap with oxygen at night. This was reported on to the night nurse by both the charge nurse as well as the unit LPN from the shift. Residents [sic] wife brought the bi-pap in from home to be utilized and the machine was present at bedside. Discussed with nurse who worked the night shift in regards to the use of the bi-pap and he confirmed that he was not given the report that the resident was to use	F 309	interviewed regarding resident condition/incident of concern. Staff member suspended, and terminated as a result of the investigation, including staff acknowledging that the plan of care for the resident required application of bipap, and of his failure to follow resident plan of care. Ongoing Compliance: Staff provided education on requirement to always follow residents plan of care, of compliance with following facility VA policy at staff meeting on January 21, 2016. Staff performance will be monitored and performance concerns addressed as they occur. Structured process for shift to shift report developed, auditing of process will be completed, results reported to LTC Quality Committee. Charge nurses and managers will monitor staff performance including staff compliance with following residents plan of care via quality monitoring tool, monitoring will occur on all three shifts. Results of quality monitoring activities will be reported to LTC Quality committee monthly x 3 months, quarterly thereafter.	

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F 309	Continued From page 16 bi-pap and the bi-pap was available but he did not place it on the resident during his shift. There were no vital signs documented per protocol for this resident and scheduled neb [nebulizer] treatment was not administered in a timely manner by the nurse providing care. Disciplinary action has been completed with this employee leading to termination of employment for failure to follow the plan of care for this resident. The resident was transferred to Sioux Falls after the ER visit on the morning of 4/10/15 and admitted to their hospital for further care. Expectation of all staff is to read and understand the plan of care for the residents which they are responsible to provide care for." During interview with the director of nursing (DON) on 12/17/15 at 10:51 a.m., the DON stated R128 was discovered with a low oxygen saturation on the morning of 4/10/15. The DON verified the bi-pap had not been on and that staff had responded immediately by sending him [R128] to the ER for evaluation. The DON stated because it was morning time R128 would not necessarily have needed to have the bi-pap machine on when it was discovered by staff. The DON stated, "I feel like the staff responded appropriately at the time of the incident by sending him to the ER." The DON stated that through her investigation on 4/13/15, it was determined the bi-pap had not been used for R128 the night of 4/9/15 so she'd filed a report to the SA because the nurse failed to follow the resident's plan of care. The DON stated she was unable to conclude whether or not having the bi-pap machine caused the low oxygen saturation due to R128's condition.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		1/26/16

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F 323	Continued From page 17 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to assess for the safe use of an assist bar which did not meet the Federal Drug Administration (FDA) guidelines to prevent entrapment for 1 of 35 residents (R6) reviewed for accidents and hazards related to a large gap in the center of the assist bar. Findings include: During an observation on 12/15/15. at 3:20 p.m. R6's bed had an assist bar located on the exit side of the bed located at the head of the bed. The opening measured 7 1/2 x 12 inches which was larger than the Key Body Part Dimensions pg. 12 of FDA guidance. R6's care plan dated 10/1/15, indicated extensive assist of 2 with use of the mechanical lift for transfers and total assist of 1-2 with bed mobility. Further review of R6's medical record did not include an assessment for the safe use of the assist bar. During observation of R6's room on 12/15/15, at 6:45 p.m. the director of nursing (DON) confirmed the opening of the assist bar was too wide and	F 323	Improper grab bar was removed from residents room and appropriate grab bar placed to meet safety and regulatory requirements. Assessment completed and interventions put into place for this resident. Residents throughout the facility assessed for appropriate grab bar use and that devices being used meet requirements. Ongoing compliance: Facility restraint/bed mobility policy updated to include quarterly tracking of appropriate grab bar use noting that all requirements for use of grab bars are being met. Siderail/grab bar assessment will be completed on admission for all residents and as determined that there is a new need for siderail/grab bar use. Facility has identified a grab bar product that will be used consistently for all residents who have been identified for appropriate use. Education to staff on new policy requirements will be reviewed at February staff meetings. Action plan developed that includes policy update, staff education, and quality monitoring	

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F 323	Continued From page 18 further stated being unaware this type of assist bar had been attached to the resident's bed. DON stated she would notify maintenance to replace as other assist bars were available for use. The DON reviewed R6's medical record and confirmed an assessment had not been completed related to the safe use of side rails/assist bars. The policy titled Restraint/Bed Mobility Device Use revised 4/2015 included: "Bed Mobility device: side reail, grab bar, overbed trapeze. Gaps/widths between handles on devices must be 4 3/4 inches or less." The Guidance for Industry and FDA (Federal Drug Administration) Staff Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment manual dated 3/10/06, identified Zone 1 as the area, "any open space within the perimeter of the rail". It also noted HBSW [Hospital Bed Safety Workgroup] and IEC [International Electrotechnical Commission] recommend the space be less than 4 3/4 inches, representing head breadth.	F 323	activities. Results of quality monitoring will be brought to quality meeting quarterly.	
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.	F 325		1/26/16

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F 325	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure individualized nutritional approaches were implemented for 1 of 2 residents (R42) reviewed for nutrition. Findings include: R42's current diagnoses, according to a history and physical dated 10/13/15, included dementia. The history and physical did not address R42's appetite nor weight loss. R42's most recent Care Area Assessment (CAA) for nutrition dated 3/12/15, indicated a body mass index (BMI) of 18.8 and that staff were to encourage supplements. R42's nutrition assessment, dated 12/8/15 indicated staff to offer Ensure (a nutritional supplement) at & between meals and at hour of sleep (HS) and received a regular diet with intakes ranging 50-75%. R42's BMI was listed at 17.5 with a goal range of 18.5-24.9. Dietician aware of weight loss, continue to monitor as needed. R42's weight had decreased from 106 pounds (lbs) 6 months ago to a current weight of 96 lbs. R42's care plan dated 12/21/15, indicated a nutrition goal which identified to maintain my weight, with interventions of, offer me a supplement at meals if my intakes are less than 50%. Please offer me high calorie snacks or a supplement between meals and at bedtime to	F 325	Nutritional plan for resident 42 updated to include specific nutritional supplements. Ongoing compliance: Facility policy on Menu planning and meal service updated to show process for identifying and providing nutritional care for high nutrition risk residents. Nutrition interventions for high risk residents set up in the EMR. Staff education will be provided on identifying high nutrition risk residents and the process that should be followed to provide appropriate snacks and documentation. This education will be provided at the January 20, 2016 staff meetings. Quality monitoring tool has been developed to track compliance with snack requirements for high risk residents. results will be reported at LTC quality meetings monthly x3 months and quarterly thereafter.	

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supplement my intake, refer to snack intervention.

Review of R42's supplement and meal intakes for previous two months revealed R42 routinely received snacks such as rolls, ice cream, brownies, cheese cake and ice cream cups that were documented as snack/supplement consumed but reflected inconsistent documentation related to the Ensure or another high calorie, high protein supplement being offered. R42's intake of the dessert-type snacks was usually 75-100%.

R42's meal intakes for 11/15 and 12/15 ranged 25-75%, with the greatest meal intakes documented at the breakfast meal.

During continuous observation on 12/15/15, from 5:40 p.m. to 6:10 p.m., R42 was observed at the dining room table. No staff were observed sitting or cueing her, and R42 repeatedly adjusted her utensils. R42 ate approximately 25% of a lettuce salad, two bowls of jello and bites of lasagna and a sandwich. At 6:10 p.m., nursing assistant (NA)-A walked by R42 lifting up her napkin and stating "oh, you got lasagna and a sandwich," then took her tray away.

During interview on 12/15/15, at 6:16 p.m. NA-A indicated R42 generally was not a big eater, "she did pretty good today," and stated staff generally cued her to eat. NA-A stated R42 took Ensure supplement and that this documentation should be in the electronic chart.

During interview on 12/16/15, at 11:45 a.m. R42's nurse manager, RN-A, stated dietary supplements were not a specific doctor order, but

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were put in as an intervention for staff to chart on by dietary. RN-A further stated there were a variety of supplements available on the units that could be given including magic cups and Ensure. RN-A would expect staff to check with R42 every once in a while during the meal to cue her to eat, but did not expect staff to be seated next to her.

During observation on 12/16/15, at 7:23 a.m. R42 was seated in the dining area, eating bites of egg bake in front of her. No staff were observed cueing her to eat.

During interview on 12/16/15, at 11:26 a.m., NA-B stated R42 received a variety of supplements between meals, usually Boost supplement or ice cream.

During observation on 12/16/15, at 12:18 p.m. R42 was observed at lunch taking bites from a variety of things on her plate including pistachio dessert, cottage cheese and potato salad. At 12:27 p.m., NA-C picked up her tray after R42 had finished, stating R42 had only eaten about 25% and was "not a very good eater."

During interview on 12/16/15, at 9:31 a.m. the dietary manager (DM), stated R42's supplements were electronically documented as an intervention. R42's intervention indicated for R42 to be offered supplements or a snack. The DM further clarified no specific supplement was ordered for R42; staff provided whatever was on hand. The DM stated a BMI below 19.0 would become a concern, and when supplements were initiated, she considered ice cream a nutrient dense food. The DM stated all residents are weighed weekly, and she reviewed them every Monday with the RN in charge of R42's unit. The

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F 325	Continued From page 22 DM was usually concerned with a loss of 3 lbs or so in a week. During interview on 12/16/15, at 11:45 a.m. RN-A stated supplements were not a specific doctor order and were put in as an intervention. R42 could receive a variety of things such as a magic cup or ensure as there were several products on the unit. During interview on 12/16/15, at 1:12 p.m. the registered dietician (RD) stated the facility could "do a better job" of spelling out the supplements residents were supposed to be on/provided. The RD generally liked to try regular food items first, then supplements. The RD indicated for R42 this was just spelled out as "supplement" on her treatment record and so they fixed this today after a discussion with the DM. The RD stated without a specific supplement or nutritional intervention in place, it could be hard to see what they liked or didn't like for food items and to evaluate their effectiveness. The facility policy, entitled Nutrition Plan of Care and Assessment, last revised 4/14 indicated in section G. that a plan for nutrition therapy is developed and implemented and documentation is made in the medical record as appropriate. This plan may include, but is not limited to: performing diet calculations, developing meal patterns, and individualizing the diet, etc.	F 325		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name.	F 356		1/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245228	A. BUILDING ______ B. WING ______	12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTER	300 SOUTH BRUCE STREET MARSHALL, MN 56258

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F 356	Continued From page 23 o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to post the current days staffing information on 2 of the 4 days of the survey. Findings include: Upon entrance on 12/14/15, at 10:45 a.m. the facility staffing information was reviewed;	F 356	Facility policy created to identify requirements for daily posting of nurse staffing information. Education to staff regarding requirements will be completed during February staff meetings. Policy and procedure will be added to orientation for all licensed nursing staff. Quality monitoring tool will be developed to track compliance with posting of nurse staffing	

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F 356	Continued From page 24 12/14/15 was not posted. The staffing information posted was dated 12/8/15 (6 days earlier). On 12/16/15, at 3:20 p.m. the daily staffing information was again reviewed; 12/15/15 was the posted day (the prior day). On 12/14/15, at 10:50 a.m. administrative assistant- A verified the posting for 12/14/15 was not correct. On 12/16/15, at 4:00 p.m. the director of nursing (DON) was shown the posting and verified the posting was not correct. She stated she forgot to post the correct day.	F 356	information. Compliance tracking results will be reported at LTC quality meetings monthly x3 months and quarterly thereafter.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441		1/26/16

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F 441	Continued From page 25 (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a glucometer was properly cleaned between resident use for 1 of 1 resident (R64) observed on Horizon neighborhood #1 during a blood sugar. In addition, the facility failed to ensure proper hand hygiene during personal care for 1 of 2 residents (R50) observed for activities of daily living. Findings include: On 12/16/15, at 7:57 a.m. trained medication aide (TMA)-A was observed to obtain a glucometer from registered nurse (RN)-B who was in a resident's room; surveyor did not observe if RN-B had cleaned the glucometer prior to handing off to TMA-A. TMA-A then went to R64's room and obtained a blood sugar (BS) from the resident; upon completion she placed the glucometer into her pocket and assisted the resident into the dining room for breakfast. When TMA-A returned	F 441	Action plan created to address infection prevention deficiency. Facility policy on use of glucose meter reviewed and updated. New competency developed to validate staff compliance with policy requirements. All staff who perform glucose testing will have a competency completed to validate compliance with policy. Staff observations will be completed to verify compliance. Results of staff competency will be brought to LTC quality committee monthly x3 months and quarterly thereafter. Ongoing compliance: Hand Hygiene Education at staff meetings will include proper use of gloves and demonstration with the use of the Glo Germ machine to show staff results of non compliance without proper hand hygiene. Monitoring staff compliance with hand hygiene	

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F 441	Continued From page 26 from the dining room at 8:11 a.m., TMA-A was questioned about the process upon completion of a blood sugar check. TMA-A indicated the glucometer would be taken to the docking station. TMA-A then removed the glucometer from her pocket and placed it in the docking station located at the nursing station. No cleaning was noted prior to placement. When questioned how often the glucometer was cleaned, TMA-A stated she thought it might be the night shift's responsibility. TMA-A then confirmed she had not cleaned the glucometer prior to nor after checking R64's BS and further confirmed it was not her practice to do so. When interviewed on 12/16/215, at 8:25 a.m. RN-B stated glucometers are to be cleaned with a Sani-wipe after each resident use. When questioned whether RN-B had cleaned the glucometer prior to giving it to TMA-A, RN-B confirmed she had not. RN-B further confirmed she had utilized the glucometer to take a BS prior to giving the equipment to TMA-A. When interviewed on 12/16/15, at 2:25 p.m. the director of nursing (DON) stated it was the expectation that glucometer equipment be cleaned after each resident use. DON confirmed not cleaning the glucometer between residents was an infection control issue. R50's diagnoses, according to physician's progress notes dated 12/1/15, included end-stage dementia. R50's annual Minimum Data Set (MDS), dated 10/18/15 indicated R50 was extensive assistance of two staff for grooming. The MDS indicated R50 was rarely or never understood and had	F 441	requirements through direct observation and results brought to quality on a monthly basis x3 months and quarterly thereafter.	

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F 441	Continued From page 27 short and long-term memory loss. A Care Area Assessment (CAA) for activities of daily living did not trigger with this assessment. R50's care plan, dated 2/16/12 and provided by the facility as the most current copy, indicated she was total assistance of one staff for bathing and required assist of one to two staff for grooming and oral care. During observation of personal cares on 12/16/15, at 8:41 a.m. nursing assistant (NA)-B was observed getting R50 up for the day. After cleansing R50's upper body and application of lotion, NA was observed to change her gloves and proceeded to cleanse R50's peri area and apply a powder for redness to her groin. NA-B removed her gloves, then proceeded to dress R50's lower body and assist to get her in a wheelchair with NA-C. Without washing her hands, NA-B applied new gloves, gathered materials for R50's oral care and proceeded to brush her teeth. During interview on 12/16/15, at 8:56 a.m. NA-B confirmed she had not washed her hands after providing R50's peri care and before putting on the new set of gloves to complete oral cares. During interview on 12/16/15, at 2:38 p.m. the director of nursing (DON) stated it would be her expectation that staff would wash their hands any time they removed soiled gloves. The facility policy, entitled Hand Washing Procedure, last revised 11/15 indicated staff should wash their hands before and after wearing gloves for any procedure.	F 441		

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F 465	Continued From page 28	F 465		
F 465 SS=B	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 facility failed to ensure resident rooms were kept in good repair for 15 of 73 resident rooms (R3, R5, R10, R19, R24, R42, R45, R48, R51, R53, R57, R59, R62, R70 & R73) which had damaged walls and door frames reviewed during the environmental tour and failed to ensure 1 of 1 resident (R42) bathroom was free of offensive odor. Findings include: During the initial tour on 12/14/15, at 11:00 a.m. the multiple resident rooms were noted to have paint scraped off the walls: On first floor, Unit 2, room 104 (R62) was noted to have paint and plaster scraped off the corner of a wall, exposing the metal corner; room 123 (R57) had large areas of paint scraped off the lower portion of wall; room 115 (R3) was observed with paint and plaster scraped off the corner of a wall exposing the metal corner; room 106 (R45) had a quarter-sized hole in the wall behind the resident's recliner; room 117 (R24) had paint scraped off the wall exposing the plaster and room 113 (R59) had paint scraped off the wall near the bathroom.	F 465	Meeting held with LTC administration and maintenance to develop plan to have all identified room repairs completed. Resident door frames will be painted and a protective vinyl covering ordered for each resident door. Ongoing compliance: Facility policy on LTC room maintenance and repairs updated and reviewed with maintenance staff. Maintenance will conduct quarterly rounds of residents rooms, bathrooms, bathing areas, utility rooms, and public areas. A list of all repairs will be forwarded to the facilities painter. A log will be kept of needed repairs and completion of repairs. Results of quality monitoring will be reported to the LTC quality committee on a quarterly basis.	1/26/16

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F 465	Continued From page 29 On first floor, unit 1, four rooms (R53, R51, R10, R73) were noted with scraped walls. On ground floor, unit 2, five rooms (R5, R19, R42, R48, R70) were noted with scraped walls. During the environmental tour on 12/16/2015, at 11:15 a.m. the maintenance manager (MM)verified all hallway door frames on first floor unit 2 had chipped off paint. The maintenance manager further verified the above rooms had scraped off paint and some gouges on the walls, stating, "It is a challenge to keep the walls free of scrapes. The hardest unit is first floor unit 2; they seem to have the lifts and other equipment." The MM further reported the resident rooms are audited on a quarterly basis, repair issues are noted and subsequently, the paint person is notified and upon completion of the work, it is checked/signed off. Review of the most recent Long Term Care (LTC) Room Maintenance documentation available was dated June, July, August of 2015. It indicated only one of four units was audited/rounded on. The maintenance manager reported they round/audit a different unit/quarter. No documentation was available for September, October, November 2015 to indicate environmental audits had been ongoing. The facility policy entitled Maintenance and Repair, dated 11/7/08 indicated maintenance will conduct quarterly rounds of resident rooms, bathrooms, bathing areas, utility rooms and public areas. Staff will monitor for chipped paint on walls, door frames, soiled ceiling tiles, floor condition, call cord condition, lighting, window treatment and report findings to department supervisor.	F 465		

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F 465	Continued From page 30 During the initial tour on 12/14/15, at 11:00 a.m. and subsequent observations the bathroom in room 28 (R42) had a strong unpleasant, old urine odor present. During an observation and interview on 12/16/15, at 11:50 a.m. with the housekeeping (H)-A manager for LTC, the bathroom in room 28 was observed and noted to smell of old urine. H-A acknowledged the problem stating "we have been working on it for a year". She further stated "maybe the odor is coming from under the floor boards" and indicated she wanted it removed/replaced. She further stated, "The floor has been stripped 3 times this year. We changed out the toilet riser and got a new one. The riser is to be cleaned under it daily and the floor mopped". H-A then lifted up the riser and it was noted to be discolored and stained on the underside of the toilet riser and the top of the toilet bowl rim. H-A then reported that the homemakers clean the rooms on a regular schedule, clean bathrooms daily and she follows up with monthly "spot checks". She indicated that she spoke with the maintenance manager "awhile ago" but had not made out a formal work order to fix the identified concern. When interviewed on 12/17/15, at 8:44 a.m. H-B provided the housekeeping room cleaning schedules. During a direct observation at the above time H-B states, "We've had this trouble before, the odorizer doesn't seem to help. The riser has rust and staining on it, I can't get it off. Other rooms smell too." She further indicated that all bathrooms were mopped and cleaned daily. During interview on 12/17/15, at 8:39 a.m.	F 465		

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F 465	Continued From page 31 nursing assistant (NA)-B stated when the usual housekeeper on the unit was gone, the NA staff do the cleaning. This would include cleansing of the bathroom, sink, dusting, handrails and mopping all areas of the room. The facility policy entitled Dailey [sic] Room Cleaning, undated, indicated to wipe down all hard surfaces, clean all door handles and light switches, clean the bathroom, counter top mirror sink, clean the toilet, get the garbages, mop bathroom & vacuum the room.	F 465		

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	245228	A. BUILDING 02 - NEW BUILDING AND RENOVATED EXISTING BLD B. WING ______	12/16/2015

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K 000	INITIAL COMMENTS	K 000		

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, State Fire Marshal Division, on February 4, 2015.. At the time of this survey, Avera Marshall Regional Medical Center Nursing Home 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 18 New Health Care Occupancies.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145
Facsimile: 651-215-0525, or

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 01/18/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245228	A. BUILDING **02 - NEW BUILDING AND RENOVATED EXISTING BLD** B. WING ______	12/16/2015

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K 000	Continued From page 1	K 000		

By e-mail to:
Marian.Whitney@state.mn.us

or
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.

Avera Marshall Regional Medical Center Nursing Home was constructed as follows:
The original building was constructed in 1963, it is two-stories in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction;
The 2004 Addition is two-stories in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction.

The nursing home is separated from an attached hospital by 2-hour fire rated wall assemblies. The building has a fire alarm system with smoke detection in the corridors, which is monitored for automatic fire department notification. Additionally, all Resident Rooms are equipped with automatic smoke detection. The facility has a capacity of 76 beds and had a census of 76 at time of the survey.

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	245228	A. BUILDING **02 - NEW BUILDING AND RENOVATED EXISTING BLD** B. WING	**12/16/2015**

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K 000	Continued From page 2 Due to the extensive renovation of the original 1963 building, the entire facility was surveyed as one building at NFPA 101 (2000) Chapter 18 New Health Care Occupancies. 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 Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection from 1 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (00) section 18.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities for residents, staff and visitors. Findings include: On facility tour between 8:30 am to 12:30 pm on 12/16/2015, observations revealed, that the door to the soiled utility room located on the GF-1 level did not have a listed fire door rating.	K 029	A replacement door with a 90 minute fire rating has been ordered for the soiled utility room and will be installed as soon as it arrives. A PO for the door purchase was issued on 1/14/16. Lead time for door arrival is 5-6 weeks from the date of the approved drawings.	1/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245228	A. BUILDING **02 - NEW BUILDING AND RENOVATED EXISTING BLD** B. WING ______	12/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTER	300 SOUTH BRUCE STREET MARSHALL, MN 56258

(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 029	Continued From page 3 This deficient practice was verified by the Maintenance Manager [DS]	K 029		
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility failed to keep the means of egress continuous and free of all obstructions or impediments to full instant use in the case of fire or other emergency, in accordance with NFPA Life Safety Code 101 (2000 edition) Chapter 7, Section 7.1.6.2 This obstruction could interfere with the convenient and effective removal all residents, staff and visitors in an emergency situation. Findings include: On facility tour between 8:30 am to 12:30 pm on 12/16/2015, it was observed that the elevation of the sidewalk out side of the GF-2 exit exceeded the maximum elevation differecnce without providing a ramp or bevel. This deficient practice was verified by the Maintenance Manager [DS]	K 072	facility will be installing a ramp to meet the maximum elevation requirements. In the Spring a concrete contractor will be hired to come and re-level the pad for proper elevation. It is not possible to do quality cement work with winter weather conditions.	1/26/16