DEPARTMENT OF HEALTH A	ND HUMA	N SERVICES		CENTERS FOR MEI	DICARE & MEDICAID SERVICES
	MEDICA	ARE/MEDICAII	CERTIFICATION	AND TRANSMITTAL	ID: DGKY
	PART I -	TO BE COMPL	ETED BY THE STA	ATE SURVEY AGENCY	Facility ID: 00365
1. MEDICARE/MEDICAID PROVIDER NO.(L 1) 245315			DRESS OF FACILITY IEALTH CARE CENT	ER	 4. TYPE OF ACTION: <u>7</u>(L8) 1. Initial 2. Recertification
2. STATE VENDOR OR MEDICAID NO. (L 2) 541743100		(L4) 303 BROAD (L5) TRIMONT , 1	WAY AVENUE SOUTI MN	I (L6) 56176	3. Termination4. CHOW5. Validation6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9)	ERSHIP	7. PROVIDER/SUI	PPLIER CATEGORY 05 HHA 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 8/2/201 8. ACCREDITATION STATUS:	6 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 10 NF 07 X-Ray 11 ICF/I	14 CORF	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other	(===)	04 SNF	08 OPT/SP 12 RHC	16 HOSPICE	09/30
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS:		
From (a):		A. In Complian	nce With	And/Or Approved Waivers Of	The Following Requirements:
To (b):		X Program Re		2. Technical Personnel	6. Scope of Services Limit
		Compliance	Based On:	3. 24 Hour RN	7. Medical Director
12 Total Englishy Pada	26 (I 18)	1. Ac	ceptable POC	4. 7-Day RN (Rural SN	NF) 8. Patient Room Size
5	36 (L18)	DUDIcture	iith ID	5. Life Safety Code	9. Beds/Room
13.Total Certified Beds	36 (L17)	1	lianceIwithIProgram and/or Applied Waivers:	* Code: A*	(L12)
14. LTC CERTIFIED BED BREAKDOWN				15. FACILITY MEETS	()
18 SNF 18/19 SNF	19 SNF	ICF	IID	1861 (e) (1) or 1861 (j) (1):	(L15)
36	17 5141	ici	IID		(===)
(L37) (L38)	(L39)	(L42)	(L43)		
16. STATE SURVEY AGENCY REMARK	S (IF APPLICA	ABLE SHOW LTC CA	NCELLATION DATE):	L	
17. SURVEYOR SIGNATURE		Date :		18. STATE SURVEY AGENCY	APPROVAL Date:
Joseph Garvey, HFE NE II		8/	11/2016 (L19)	Kamala Fiske-Downing, Healt	th Program Representative 8/11/2016 (L20)
PART I	I - TO BE	COMPLETED B	Y HCFA REGIONA	L OFFICE OR SINGLE S	
19. DETERMINATION OF ELIGIBILITY			PLIANCE WITH CIVIL		ncial Solvency (HCFA-2572)
1. Facility is Eligible to Partici	pate	RIGH	TS ACT:	 Ownership/Control Both of the Above 	ol Interest Disclosure Stmt (HCFA-1513) e :
2. Facility is not Eligible					
	(L21)				
22. ORIGINAL DATE 23	LTC AGREE	MENT 24	. LTC AGREEMENT	26. TERMINATION ACTION:	: (L30)
OF PARTICIPATION	BEGINNING	6 DATE	ENDING DATE	VOLUNTARY 00	INVOLUNTARY
06/01/1986				01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)	02-Dissatisfaction W/ Reimburse	
25. LTC EXTENSION DATE: 27.	ALTERNATI	VE SANCTIONS		03-Risk of Involuntary Terminatio	OTHER
	A. Suspension	n of Admissions:		04-Other Reason for Withdrawal	07-Provider Status Change
(L27)	D.D. 1.10		(L44)		00-Active
	B. Rescind Si	spension Date:			
28. TERMINATION DATE:	20	. INTERMEDIARY/	(L45)	30. REMARKS	
28. TERMINATION DATE.	25		ARRIER NO.	50. REWARKS	
		03001			
((L28)		(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL DATE	-	
(L32)		(L33)	DETERMINATION APPI	ROVAL



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245315

August 11, 2016

Ms. Patrice Goette, Administrator Trimont Health Care Center 303 Broadway Avenue South Trimont, MN 56176

Dear Ms. Goette:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective July 15, 2016 the above facility is certified for:

36 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 36 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,

Kumala Fiske Downing

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



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered August 11, 2016

Ms. Patrice Goette, Administrator Trimont Health Care Center 303 Broadway Avenue South Trimont, MN 56176

RE: Project Number S5315025

Dear Ms. Goette:

On June 22, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 9, 2016. 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 August 2, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on July 24, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 9, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 15, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 9, 2016 and therefore remedies outlined in our letter to you dated June 22, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

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

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building		DATE OF REVIS	IT
	B. Wing	Y2	8/2/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
TRIMONT HEALTH CARE CEN	ITER	303 BROADWAY AVENUE SOUTH		
		TRIMONT, MN 56176		

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).

ITE	M	DATE	ITEM			DATE	ITEM			DATE
Y4		Y5	Y4			Y5	Y4			Y5
ID Prefix	F0242	Correction	ID Prefix	F0272		Correction	ID Prefix	F0278		Correction
Reg. #	483.15(b)	Completed	Reg. #	483.20(l	b)(1)	Completed	Reg. #	483.20(g) - (j)		Completed
LSC		07/08/2016	LSC			07/08/2016	LSC			07/08/2016
ID Prefix	F0279	Correction	ID Prefix	F0309		Correction	ID Prefix	F0315		Correction
Reg. #	483.20(d), 483.	20(k)(1) Completed	Reg. #	483.25		Completed	Reg. #	483.25(d)		Completed
LSC		07/08/2016	LSC			07/08/2016	LSC			07/08/2016
ID Prefix	F0371	Correction	ID Prefix	F0520		Correction	ID Prefix			Correction
Reg. #	483.35(i)	Completed	Reg. #	483.75(o)(1)	Completed	Reg. #			Completed
LSC		07/08/2016	LSC			07/08/2016	LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC			LSC				LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC			LSC				LSC			
REVIEW		REVIEWED BY (INITIALS)	DATE		SIGNATURE OF	SURVEYOR			DATE	
		KS/kfd	8/11/201				22113		8/	/2/2016
REVIEWI CMS RO		REVIEWED BY (INITIALS)	DATE		TITLE				DATE	
FOLLOW 6/9/2016		Y COMPLETED ON			ANY UNCORRECTED DEFICIENCI				🗌 YE	s 🗌 no

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POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01		DATE OF	REVISIT
	B. Wing	Y2	7/24/201	16 _{Y3}
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
TRIMONT HEALTH CARE CEN	TER	303 BROADWAY AVENUE SOUTH		
		TRIMONT, MN 56176		

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).

	EM ′4		DATE Y5	ITEN Y4	I		DATE Y5	ITEM Y4			DATE Y5
ID Prefix	~		Correction	ID Prefix			Correction	ID Prefix			Correction
ID FIEID			Correction	ID FIEIK		101	Correction	ID FIElix			Correction
Reg. #	NFPA 101		Completed	Reg. #	NFPA	101	Completed	Reg. #	NFPA 101		Completed
LSC	K0021		07/15/2016	LSC	K0022		06/20/2016	LSC	K0029		07/15/2016
ID Prefix	x		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	NFPA 101		Completed	Reg. #	NFPA	101	Completed	Reg. #	NFPA 101		Completed
LSC	K0033		07/15/2016	LSC	K0034		06/28/2016	LSC	K0047		07/15/2016
ID Prefix	x		Correction	ID Prefix			Correction	ID Prefix			Correction
D "	NFPA 101		- 	_ "	NFPA	101	_		NFPA 101, 483	.70(a)(7)	-
Reg. #			Completed	Reg. #			Completed	Reg. #			Completed
LSC	K0050		06/29/2016	LSC	K0051		07/15/2016	LSC	K0053		07/15/2016
ID Prefix	x		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	NFPA 101		Completed	Reg. #	NFPA	101	Completed	Reg. #	NFPA 101		Completed
LSC	K0054		06/27/2016	LSC	K0056	i	07/15/2016	LSC	K0062		06/22/2016
ID Prefix	x		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	NFPA 101		Completed	Reg. #	NFPA	101	_ Completed	Reg. #	NFPA 101		Completed
LSC	K0064		06/08/2016	LSC	K0070		06/30/2016	LSC	K0072		06/08/2016
		REVIEV (INITIAL		DATE		SIGNATURE O	FSURVEYOR	1		DATE	
		<u> </u>	kĺd	8/11/20	16			354	82		4/2016
REVIEV CMS RO	VED BY	REVIEV (INITIAL		DATE		TITLE				DATE	
Form CI	MS - 2567B (09/9	2) EF (11	/06)			Page 1 of 2			EVENT ID:	DGKY2	22

EVENT ID: DGKY22

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01		DATE OF REV	/ISIT
	B. Wing	Y2	7/24/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
TRIMONT HEALTH CARE CEN	ITER	303 BROADWAY AVENUE SOUTH		
		TRIMONT, MN 56176		

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).

ITE		DATE	ITEM		DATE	ITEM		DATE
Y4	ŀ	Y5	Y4		Y5	Y4		Y5
ID Prefix	NFPA 101	Correction	ID Prefix	A 101	Correction	ID Prefix	NFPA 101	Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC	K0074	07/15/2016	LSC K00	76	06/23/2016	LSC	K0144	06/30/2016
ID Prefix		Correction						
Reg. #	NFPA 101	Completed						
LSC	K0147	06/29/2016						
				- 1				
REVIEW STATE A		REVIEWED BY (INITIALS)	DATE	SIGNATURE OF	SURVEYOR			DATE
REVIEW	ED BY	TL/kfd REVIEWED BY	8/11/2016 DATE	TITLE		35482		7/24/2016 DATE
CMS RO		(INITIALS)						
FOLLOV 6/8/2016		COMPLETED ON	CHECK F UNCORR	OR ANY UNCORREC	CTED DEFICIEN ES (CMS-2567)	ICIES. WAS SENT TO T	A SUMMARY OF HE FACILITY?	YES NO



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

August 11, 2016

Ms. Patrice Goette, Administrator Trimont Health Care Center 303 Broadway Avenue South Trimont, MN 56176

Re: Reinspection Results - Project Number S5315025

Dear Ms. Goette:

On August 2, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 2, 2016. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kumala Fiske Downing

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

STATE FORM: REVISIT REPORT

	MULTIPLE CONSTRUCTION			DATE OF REVIS	SIT
IDENTIFICATION NUMBER	A. Building				
00365 _{Y1}	B. Wing	,	Y2	8/2/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
TRIMONT HEALTH CARE CEN	ITER	303 BROADWAY AVENUE SOUTH			
		TRIMONT, MN 56176			

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITE	М	DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix	20255	Correction	ID Prefix	20540	Correc	tion ID Prefix	20560	Correction
Reg. #	MN Rule 4658.00	70 Completed	Reg. #	MN Rule 4658.0 Subp. 1 & 2	400 Comple	eted Reg. #	MN Rule 4658.04 Subp. 2	05 Completed
LSC		07/08/2016	LSC		07/08/20	D16 LSC		07/08/2016
ID Prefix	20830	Correction	ID Prefix	20910	Correc	tion ID Prefix	21015	Correction
Reg. #	MN Rule 4658.05 Subp. 1	20 Completed	Reg. #	MN Rule 4658.0 Subp. 5 A.B	525 Comple	eted Reg. #	MN Rule 4658.06 Subp. 7	Completed
LSC		07/08/2016	LSC		07/08/20	D16 LSC		07/08/2016
ID Prefix	21375	Correction	ID Prefix	21830	Correc	tion ID Prefix	21915	Correction
Reg. #	MN Rule 4658.08 Subp. 1	00 Completed	Reg. #	MN St. Statute 1 Subd. 10	44.651 Comple	eted Reg. #	MN St. Statute 14 Subd. 27	44.651 Completed
LSC		07/08/2016	LSC		07/08/20	D16 LSC		07/08/2016
ID Prefix		Correction	ID Prefix		Correc	tion ID Prefix		Correction
Reg. #		Completed	Reg. #		Comple	eted Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correc	tion ID Prefix		Correction
Reg. #		Completed	Reg. #		Comple	eted Reg. #		Completed
LSC			LSC			LSC		
REVIEW		REVIEWED BY	DATE	SIGNAT	URE OF SURVEY	OR		DATE
STATE A		(INITIALS) KS/kfd	8/11/20	16		221	13	8/2/2016
REVIEW		REVIEWED BY (INITIALS)	DATE	TITLE				DATE
FOLLOW 6/9/2016		COMPLETED ON			ICORRECTED DE FICIENCIES (CMS			YES NO

DEPARTMENT OF HEAI	TH AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: DGKY
	PART I -	TO BE COMPI	LETED BY 1	ГНЕ STAT	FE SURVEY AGENCY	Facility ID: 00365
1. MEDICARE/MEDICAID PROV NO.(L 1) 245315	IDER	3. NAME AND AL (L3) TRIMONT			CR	4. TYPE OF ACTION: <u>2</u> (L8) 1. Initial 2. Recertification
2. STATE VENDOR OR MEDICA (L 2) 541743100	ID NO.	(L4) 303 BROAD (L5) TRIMONT,		E SOUTH	(L6) 56176	3. Termination4. CHOW5. Validation6. Complaint
5. EFFECTIVE DATE CHANGE C (L9)	OF OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEO 05 HHA	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 0	5/09/2016 ^(L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Othe	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC	15 ASC 16 HOSPICE	09/30
11. LTC PERIOD OF CERTIFICAT		10.THE FACILITY	IS CERTIFIED	AS:		
From (a):		A. In Complia			And/Or Approved Waivers Of	The Following Requirements:
To (b):		-	equirements		2. Technical Personnel	6 1
		Compliance	e Based On:		3. 24 Hour RN	7. Medical Director
		<u>1.</u> A	cceptable POC		4. 7-Day RN (Rural SN	
12. Total Facility Beds	36 (L18)				5. Life Safety Code	9. Beds/Room
13.Total Certified Beds	36 (L17)	X B. Not in Con Requirements	npliance with Pro and/or Applied		* Code: B *	(L12)
14. LTC CERTIFIED BED BREAK	DOWN				15. FACILITY MEETS	
18 SNF 18/19 SN 36	IF 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY RE	EMARKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Pamela Manzke, HF	E NE II	0	7/11/2016	(L19)	Kamala Fiske-Downing, Healt	th Program Representative 07/27/2016 (L20)
Р	ART II - TO BE	COMPLETED I	BY HCFA R	EGIONAL	OFFICE OR SINGLE S	TATE AGENCY
19. DETERMINATION OF ELIGI	BILITY		IPLIANCE WIT ITS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)
 Facility is Eligible t 	to Participate	KIOI	IISACI.		3. Both of the Above	
2. Facility is not Elig	ible (L21)					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREE	MENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION 06/01/1986	BEGINNING	G DATE	ENDING DA	ЛЕ	<u>VOLUNTARY</u> <u>00</u> 01-Merger, Closure	<u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	-
25. LTC EXTENSION DATE:		VE SANCTIONS	(220)		03-Risk of Involuntary Terminatio	on OTHER
25. EICENTENSION DATE.		n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)	B. Rescind St	uspension Date:	(L44)			00-Active
			(L45)			
28. TERMINATION DATE:	29	0. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	L DATE		
	(L32)			(L33)	DETERMINATION APPI	ROVAL



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered June 22, 2016

Ms. Patrice Goette, Administrator Trimont Health Care Center 303 Broadway Avenue South Trimont, Minnesota 56176

RE: Project Number S5315025

Dear Ms. Goette:

On June 9, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor Health Regulation Division Licensing and Certification Section 1400 E. Lyon St. Marshall, MN 56258 Telephone: (507) 476-4233 Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 19, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 19, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 3, 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 December 3, 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division

> 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Tomston

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure cc: Licensing and Certification File

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		OMB NC	0. 0938-0391
	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TE SURVEY MPLETED
		245315	B. WING _	06	6/09/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
TRIMON	T HEALTH CARE CEN	ITER		303 BROADWAY AVENUE SOUTH	
				TRIMONT, MN 56176	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 00	o	
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	of correction (POC) will serve of compliance upon the otance. Because you are your signature is not required first page of the CMS-2567 nic submission of the POC will tion of compliance.			
F 242 SS=D	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with ETERMINATION - RIGHT TO	F 24	2	7/8/16
	schedules, and hea her interests, asses interact with membrinside and outside t	e right to choose activities, alth care consistent with his or soments, and plans of care; ers of the community both the facility; and make choices s or her life in the facility that e resident.			
	by: Based on interview facility failed to acco 2 of 3 residents (R3 Findings include: R35 stated on 6/6/ not offered a choice (frequency) she rec	NT is not met as evidenced y and document review the commodate bathing choices for 35, R28) reviewed for choices. 16, at 3:31 p.m. that she was e in how many times a week revied a bath/shower. She ets one a week, that's what		Corrective action for those residents found to have been affected - R35 & R28 - interview regarding bathing preference and frequency using "Bath Preference Inquiry" and make changes to care plan to meet their choices. To identify other residents that may potentially be affected - the "Bath Preference Inquiry" will be completed with	
LABORATOR	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE

Electronically Signed

ined

PRINTED: 07/11/2016

06/30/2016

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.

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DAT	0938-039
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	CON	IPLETED
		245315	B. WING			09/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
TRIMON	T HEALTH CARE CE	NTER		303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIC DATE
F 242	Continued From pa	age 1	F 242	2		
	they told me when if she thought she or shower per wee	I came in here." When asked could have more than one bath k she stated, "Nope you can't.		each resident and change care planned to meet their		
	it." During an subsequ p.m. R35 stated "th	e gets one a week and that's ent interview on 6/7/16, at 1:56 ney tell you when you come in		To ensure that this doesn' Preference Inquiry" will be admission, quarterly and v changes. At each residen conference bath preference	completed at with significant it care	
	p.m. R35 stated sh than one bath as s one. She stated, " especially now that	one bath". On 6/9/16, at 11:49 he had never asked for more he was told you can only have I would like more than one t it is getting hot out."		reviewed. Education to be done with use of Bath Preference In policy and procedure rega and a refresher on the res	quiry, revised Irding bathing ident's right to	
	(MDS) assessmen had a Brief Intervie	ission Minimum Data Set t dated 3/22/16, identified R35 w for Mental Status (BIMS)		make choices regarding th routine.	-	
	of the admission n 3/15/16, identified t a.m. (morning) bat	icating intact cognition. Review ursing assessment dated that R35 preferred to take an h. It did not identify whether than one bath a week.		To monitor for compliance randomly audit the bath pr process.		
	gets "one bath a w On 6/9/16, at 11:49 when she was adm do one bath a wee never requested an she could only hav	16, at 6:01 p.m., that everyone eek, that's what they told me". a.m., R28 again stated that hitted facility staff told her, "we k here". She indicated she had nother bath as she was told e one. She stated it would be an one bath a week.				
	BIMS score of 15/1 Review of the adm	29/16, identified R28 with a 5, indicating intact cognition. ission nursing assessment did preference for bathing				

If continuation sheet Page 2 of 20

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES		07/11/2016 PPROVED 938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2)	(2) MULTIPLE CONSTRUCTION (X3) DATE S BUILDING	SURVEY
245315 B. V	WING 06/09)/2016
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176	
	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
 F 242 Continued From page 2 assistant (NA)-A stated that when residents were admitted they were given one bath a week. During interview on 6/8/16, at 8:02 a.m. the social worker (SW) stated she did not address bathing frequency upon admission as that was part of the nursing admission process. During interview on 6/8/16, at 8:15 a.m. licensed practical nurse (LPN)-A stated she had never specifically asked newly admitted residents whether they desired more than one bath a week nor was it discussed at resident care conferences. On 6/9/16, at 12:26 p.m. the administrator stated staff was supposed to ask residents whether they preferred a morning or evening bath and whether one bath a week is ok or would they like more. She stated this should be asked of all residents upon admission so they had a choice. A policy dated 9/11/08, identified the facility's staff was to assist with baths/showers "on their designated bath day." F 272 483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: 	F 242	/8/16

Facility ID: 00365

If continuation sheet Page 3 of 20

		AND HUMAN SERVICES			PRINTED: 07/1 FORM APPR OMB NO. 0938	ROVED	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURV COMPLETE		
		245315	B. WING		06/09/20	16	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
TRIMON	T HEALTH CARE CEN	NTER		303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMP	(X5) PLETION PATE	
F 272	Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior Psychosocial well-k Physical functioning Continence; Disease diagnosis Dental and nutritior Skin conditions; Activity pursuit; Medications; Special treatments Discharge potential Documentation of s the additional asses areas triggered by Data Set (MDS); ar	emographic information; patterns; being; g and structural problems; and health conditions; hal status; and procedures; l; summary information regarding ssment performed on the care the completion of the Minimum	F 27	2			
	by: Based on interview facility failed to com identify appropriate residents (R31, R2	NT is not met as evidenced y and document review, the prehensively assess and interventions for 2 of 2 8) reviewed for incontinence s (R31) reviewed for		Corrective action for R31 relate urinary incontinence - a bladder assessment to be completed ar addressed on the care plan with appropriate interventions. Corrective action for R31 relate	nd n		
	Findings include:			wandering - an elopement/wand assessment to be completed ar	dering		

Event ID:DGKY11

Facility ID: 00365

If continuation sheet Page 4 of 20

STATEMEN	OF DEFICIENCIES	KIDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED	
		245315	B. WING	uu	06/	09/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		09/2010	
	T HEALTH CARE CE	NTER		303 BROADWAY AVENUE SOUT TRIMONT, MN 56176			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLETIC DATE	
F 272	R31's admission W 12/17/16, indicated impaired, and expe- of bladder requiring hygiene. R31's qua indicated resident v indicated resident v indicated R31 was dangerous place. F look back dated 12 wandered which pl 12/15/15 and 12/16 R31's diagnoses n 1/25/16 included b and dementia withe Review of the care 12/17/15, indicated needed assistance indicated urinary in planned. However lacked analysis of include identifying order to assist with interventions. During an interview director of nurses (bladder assessment them. The DON wo would expect an un to be done. The CAA dated 12, at immediate threat the past 7 days. Th incomplete and lace	linimum Data Set (MDS) dated d R31 was severely cognitively erienced frequent incontinence g assistance with personal arterly MDS dated 3/15/16 was always incontinent which in continence. The MDS also at risk for wandering to a Review of the 7 day behavior 2/11/15 indicated R31 had aced R31 at risk of danger on	F 27	 addressed on the care p appropriate interventions Corrective action for R28 catheter - a bladder asse completed and care plan appropriate interventions and benefits; also reques from physician stating dia rationale for catheter. The facility will identify of potentially being affected bladder assessment and elopement/wandering as admission, quarterly and changes. To ensure this practice d random audits will be do and reviewed at quarterly meetings. Education to regarding bladder and elopement/wandering as policies and procedures assessments. 	s. B related to essment to be ined with s regarding risks st documentation agnosis and ther residents I by completing a l an sessment at with significant oesn't recur ne by the DON y QA & A be provided sessments and		

If continuation sheet Page 5 of 20

		AND HUMAN SERVICES				FORM	07/11/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245315	B. WING			06/0	09/2016
NAME OF I	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TRIMON	T HEALTH CARE CEN	ITER			03 BROADWAY AVENUE SOUTH RIMONT, MN 56176		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 272	regarding incontine indicated these issu During review of the dated 12/7/15, the s indicated R31 was further indicated R3 communicate need present upon referr During an interview social worker (SW) demonstrated any y further indicated R3 wandering within th The SW reported R resident's room twic wheelchair. The SV was not placed initi- but looking for his r indicated R31 did n assessment comple On 6/8/16, at 8:20 a the resident had be and was noted to w needed different pla redirect when wand indicated she was r assessment was co she would expect o adminstrator indica- a wanderguard to b resident and observ they were a known On 6/9/16 at 12:28 (DON) indicated sh	nce or wandering and ues would be care planned. e admission progress notes social worker (SW) notes a known wanderer. The notes 1 was alert, oriented, able to s with no behavior indicators al. on 6/7/16, at 2:57 p.m. the indicated the resident had not wandering at the facility. SW 1 had 2 episodes of e first weeks of admission. 31 wandered into another ce but is now immobile in the V reported a wanderguard ally as he was not exit seeking oom. The SW further ot have an elopement risk eted upon admission. a.m. the administrator reported en in an assisted living facility rander while there. R31 acement due to limited staff to lering. The adminstrator not aware if a 24-48 hour ompleted and further indicated ne to have been done. The ted she would have expected be placed and watch the ve the behavior especially if	F2	272			

If continuation sheet Page 6 of 20

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/11/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245315	B. WING	B. WING		06/	09/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
TRIMON	T HEALTH CARE CEN	ITER			03 BROADWAY AVENUE SOUTH RIMONT, MN 56176		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG F 272	Continued From par could not provide at The Elopement polit 8/18/08, indicated of all residents would of elopement. R28 was admitted work catheter. The care the rationale for the impaired mobility, of use and risk for skill R28's admission Mi assessment dated indwelling Foley cathor Care Area Assessm status which could the Foley catheter. an assessment for ongoing use of a for evidence of assess an indwelling cather the catheter and co resulting from the un catheter. On 6/9/16, at 2:09 p (DON) confirmed R	ge 6 ny further information. icy with a review date of luring the admission process be assessed for the their risk with an indwelling Foley plan dated 4/13/16, identified use of the catheter was hronic pain, chemotherapy	F 2	72			
F 278 SS=D	stated the closest ro the Foley catheter v foley catheter she c 483.20(g) - (j) ASSI ACCURACY/COOF	eason she had for the use of was, "she (R28) has a chronic came with."	F 2	78			7/5/16

If continuation sheet Page 7 of 20

CENTERS FOR MEDICARE & MEDICAD SERVICES OMB No. 0938-0311 STATEMENT OF DEFICIENCIES (M) PROVIDERUPUERCULA IDENTIFICATION NUMBER: (M) PROVIDERUPUERCULA B WING (M) PROVIDER USUPPLER COMPLETED (M) PROVIDER USUPPLER B WING (M) PROVID			AND HUMAN SERVICES				FORM	APPROVED
NAME OF PROVIDER OR SUPPLIER Image: constraint of the supplication of the superior the superior of the superior of the superior	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DATE	E SURVEY
333 BRADAWY AVENUE SOUTH TRIMONT HEALTH CARE CENTER CALL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECULTORY OR LSC IDENTIFYING INFORMATION) PHERK TAG REPOVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) CONFECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) CONFECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) CONFECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) CONFECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) CONFECTION (EACH CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) CONFECTION (EACH CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) CONFECTION (EACH CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) CONFECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) CONFECTION (EACH CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) CONFECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) CONFECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) CONFECTION (EACH CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) CONFECTION (EACH CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) CONFECTION (EACH CORRECTION (EACH CORRECTION SHOULD APPROPRIATE DEFICIENCY) CONFECTION (EACH CORRECTION (EACH CORRECTION CORRECTION TO THE DEFICIENCY)			245315	B. WING			06/(09/2016
THIMONT HEALTH CARE CENTER TRIMONT, MN 56176 (X4) ID PHEFK TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUATORY OR LSC DENTIFYING INFORMATION) ID PHEFK TAG PROVIDENTIFY TAG PROVIDENTIFY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUATORY OR LSC DENTIFYING INFORMATION) ID PAREFK TAG PROVIDENTIFY TAG PROVIDENTIFY (EACH OFRECTIVE ATOM SPROUDD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) (%) F 278 Continued From page 7 resident's status. F 278 F 278 F 278 A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. F 278 F 278 Label A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. ID ID ID ID ID ID ID ID ID ID ID ID ID I	NAME OF F	PROVIDER OR SUPPLIER						
PREFIX TAG IEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFX TAG IEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMELTION DEFICIENCY F 278 Continued From page 7 resident's status. F 278 F 278 F 278 A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. F 278 F 278 A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly certifies a material and false statement in a resident assessment in a resident assessment. Contract assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview facility failed to accurately code the Minimum Data Set (MDS) assessment for 1 of 3 residents (R10) reviewed for dental services. Corrective action - education provided on appropriate coding of MDS for staff completing Section L Oral/Dental Status.	TRIMON	T HEALTH CARE CEN	ITER					
resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1.000 for each assessment, or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview facility failed to accurately code the Minimum Data Set (MDS) assessment for 1 of 3 residents (R13) reviewed for dental services.	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE	COMPLETION
	F 278	resident's status. A registered nurse i each assessment w participation of heal A registered nurse i assessment is com Each individual who assessment must s that portion of the a Under Medicare an willfully and knowing false statement in a subject to a civil mo \$1,000 for each ass willfully and knowing to certify a material resident assessmen penalty of not more assessment. Clinical disagreemen material and false s This REQUIREMEN by: Based on observat interview facility fail Minimum Data Set residents (R13) rev	must conduct or coordinate with the appropriate th professionals. must sign and certify that the pleted. o completes a portion of the sign and certify the accuracy of ssessment. d Medicaid, an individual who gly certifies a material and a resident assessment is oney penalty of not more than sessment; or an individual who gly causes another individual and false statement in a nt is subject to a civil money than \$5,000 for each ent does not constitute a statement. NT is not met as evidenced tion, document review and ed to accurately code the (MDS) assessment for 1 of 3	F 2	278	Corrective action - education provi appropriate coding of MDS for staff completing Section L Oral/Dental S To identify residents that may be aff	tatus. fected	
Findings include:and to ensure future compliance so this deficient practice doesn't recur the DONDuring observation on 6/6/16, at 3:06 p.m. R13 was observed to have carious teeth on the topwill randomly check that the dental assessments are being completed and		During observation				deficient practice doesn't recur the will randomly check that the dental	DON	

Facility ID: 00365

If continuation sheet Page 8 of 20

PRINTED: 07/11/2016

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			()	E SURVEY
				à		
		245315	B. WING		06/	09/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
TRIMON	T HEALTH CARE CE	NTER		303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 278		A dental note dated 2/16/15,	F 278	coded accurately on the MDS p		
	the gumline. The a conducted 11/5/15 mouth and became attempted to obser of the annual Minin 11/10/15, did not ic unable to be comp was documented " present"- which ref (a.) broken or loos (b.) no natural teet abnormal mouth tis cavity or broken na bleeding gums or loos	#9 had been fractured off at nnual dental assessment identified R13 refused to open e combative when staff ve mouth and teeth. Review num Data Set (MDS) dated lentify the dental exam was leted by staff. The following none of the above were erenced the following items: ely fitting full or partial denture; h or tooth fragments; (c.) esue; (d.) obvious or likely itural teeth; (e.) inflamed or pose natural teeth; and (f.) n, discomfort or difficulty with		signing and certifying the accura		
F 279 SS=D	director of nurses (inaccurate and sho "unable to complet 483.20(d), 483.20(COMPREHENSIV	k)(1) DEVELOP	F 279			7/8/16
	to develop, review comprehensive pla The facility must de plan for each resid objectives and time medical, nursing, a	and revise the resident's				

Facility ID: 00365

If continuation sheet Page 9 of 20

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED
		245315	B. WING	3	06/09/2016	
	PROVIDER OR SUPPLIER T HEALTH CARE CE	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176	00,00,2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 279	to be furnished to a highest practicable psychosocial well-k §483.25; and any s be required under due to the resident §483.10, including under §483.10(b)(4 This REQUIREME by: Based on observa review the facility fa comprehensive can for 1 of 3 (R18) re services. Findings include: R18 had a diagnos 6:39 p.m. resident her teeth on top an her lower gum lines dentures/partials in The admission Min 3/7/16, identified R Interview for Menta severe cognitive im extensive assistant personal hygiene. as having obvious natural teeth. The 0 dated 3/7/16, ident addressed in the c Review of R18's ca	Attain or maintain the resident's physical, mental, and being as required under services that would otherwise §483.25 but are not provided 's exercise of rights under the right to refuse treatment 4). NT is not met as evidenced tion, interview and document ailed to develop a re plan related to dental care sidents reviewed for dental is of dementia. On 6/6/16, at was noted to be missing all of d had only two visible teeth on s. She did not have any the mouth. himum Data Set (MDS) dated 18 as having a BIMS (Brief al Status) score of 4 indicating pairment and needing ce of one staff member with Furthermore, it identified R18 or likely cavity or broken Care Area Assessment (CAA) ified that dental care would be	F 275	 Corrective action for R18 - develocomprehensive care plan related care based on dental assessment To identify other residents that mapotentially be affected, care plans reviewed and revised as needed taccurate ADL or self care deficit problems, goals or interventions. Education to be provided regarding development of a comprehensive plan. To ensure deficient practice does care plans will be randomly audited DON or MDS LPN. 	y to be o reflect g care	

If continuation sheet Page 10 of 20

		AND HUMAN SERVICES			FORM	07/11/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245315	B. WING		06/	09/2016
NAME OF F	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE		
TRIMON	T HEALTH CARE CEN	ITER		303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279 F 309 SS=D	Continued From pa deficit problems, go the management of During interview on assistant (NA)-B sta denture but refused stated R18 needed oral/dental cares ea During interview on director of nursing (did not include a de have. However, the assistants use the of cares. Dental care p interventions were v During interview on verified that no oral the kiosk for R18. Review of Trimont H Procedures for Care plan requirements r develop an individu plan that would include 483.25 PROVIDE Of HIGHEST WELL BI Each resident must provide the necessa or maintain the high	age 10 pals, or interventions related to f dental care. a 6/9/16, at 10:15 a.m. nursing ated R18 had an upper d to wear it. NA-B further assistance to complete her ach day. a 6/9/16, at 11:07 a.m. the (DON) confirmed the careplan ental/oral care plan, but should e DON stated the nursing care plan on the kiosk for problems, goals, and visible there. a 6/9/16, at 11:26 a.m. NA-E l/dental plan of care existed on Health Care Center Policy and re Plan Conference & Care revised 6/9/10, directed staff to valized comprehensive care ude dental condition. CARE/SERVICES FOR	F 279	DEFICIENCY)		7/8/16
	accordance with the and plan of care.	e comprehensive assessment				

Facility ID: 00365

If continuation sheet Page 11 of 20

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · /	E SURVEY PLETED	
	F CORRECTION	IDENTIFICATION NOMBER.	A. BUILDIN	IG	COM		
		245315	B. WING _			09/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
TRIMON	T HEALTH CARE CEI	NTER		303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE	
F 309	by: Based on observa review the facility facoordinated with the residents (R5) revie Findings include: R5's significant char assessment dated cognitively intact, in with activities of da prognosis of less the R5's care plan last that R5 received has hospice services we resident. The hospice plan of R5 received skilled weekly and as nee three times per moof five times per week times per month ar visits two to four time During observation nursing assistant (If aware R5 received hospice aide came time. NA-D was un disciplines from ho occurred. During observation	NT is not met as evidenced tion, interview and document ailed to ensure services were e hospice agency for 1 of 1	F 30	 Corrective action regarding I conversation with Hospice age establish a clear coordination including schedule for visiting staff and documentation and communication of visit. No other residents identified be affected. To ensure that practice will ne hospice policy and procedure developed regarding coordin services. Education to be prostaff. To monitor for compliance, fa worker/designee will random communication, documentati schedule of hospice agency a effectiveness at quarterly QA meetings. 	gency to of services, hospice at this time to ot recur a e will be ation of ovided to acility social ly audit on and and report		

If continuation sheet Page 12 of 20

		AND HUMAN SERVICES				FORM	APPROVED
	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUI	TIPI	E CONSTRUCTION		0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING			PLETED
		245315	B. WING			06/09/2016	
NAME OF F	PROVIDER OR SUPPLIER		T	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TRIMON	T HEALTH CARE CEN	ITER		-	03 BROADWAY AVENUE SOUTH		
					RIMONT, MN 56176		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	09 Continued From page 12		F 3	09			
	When interviewed of social service desig aware the hospice r the prior day and th Monday through Fri lunch. The SSD ind gave a verbal repor updates and docum However, she was n schedule nor when During interview on practical nurse (LPI came everyday at lu unaware of the hos whether there was a skilled nursing visits On 6/8/16, at 1:07 p (DON) indicated she skilled nursing visits did not know if there communicated and On 6/9/16, at 1:31 p (RN) case manager weekly and "shoots and then named Mo Wednesday. She th "target day". The ho provide a schedule facility staff when sh call the facility if she week.	on 6/8/16, at 1:05 p.m. the gnee (SSD) indicated she was nurse had been to the facility lat a hospice aide came iday to assist R5 with her licated the hospice providers t to staff with changes or nented their visit in the chart. not sure of the hospice nurses' the next visit would occur. 6/8/16, at 1:06 p.m. licensed N)-A indicated a hospice aide unch time. LPN-A was pice nurse schedule and/or an established schedule of s for R5.					
		sted, but none was provided.					

If continuation sheet Page 13 of 20

PRINTED: 07/11/2016

		AND HUMAN SERVICES			FO	ED: 07/11/2016 RM APPROVED NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			DATE SURVEY COMPLETED
		245315	B. WING			06/09/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	
TRIMON	T HEALTH CARE CEN	ITER			03 BROADWAY AVENUE SOUTH RIMONT, MN 56176	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315 F 315 SS=D		HETER, PREVENT UTI,		315 315		7/8/16
	assessment, the far resident who enters indwelling catheter resident's clinical co catheterization was who is incontinent of treatment and servi	ent's comprehensive cility must ensure that a s the facility without an is not catheterized unless the ondition demonstrates that necessary; and a resident of bladder receives appropriate ices to prevent urinary tract store as much normal bladder e.				
	by: Based on interview facility failed to com identify appropriate	NT is not met as evidenced v and document review, the prehensively assess and interventions for 2 of 2 8) reviewed for incontinence.			Corrective action for R31 - complete a bladder assessment and care plan problem with appropriate goal and interventions.	
	12/17/16, indicated impaired, and expe of bladder requiring hygiene. R31's qua indicated a decline was always incontir on the care plan da	Animum Data Set (MDS) dated R31 was severely cognitively rienced frequent incontinence assistance with personal arterly MDS dated 3/15/16, in incontinence as resident nent. R31's diagnoses noted ted 1/25/16 included benign ny and dementia without ns.			Corrective action for R28 - complete a bladder assessment and review risks a benefits of ongoing catheter use and potential of removal with consideration potential complications - care plan with appropriate goal and interventions. To identify other residents potentially at risk for this deficient practice bladder assessment to be completed at admission, quarterly and with significan changes.	of
	12/17/15 indicated needed assistance	area assessment (CAA) dated R31 had urinary urgency and in toileting. The CAA further continence would be care			Education to be provided related to poli and procedure for completion of bladde assessment to ensure deficient practice doesn't recur.	r

Facility ID: 00365

DEPARTMENT OF HEALTH				FORM	07/11/2016 APPROVED 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	245315	B. WING		06/0	09/2016
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
TRIMONT HEALTH CARE CEN	TER		303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176		
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
 lacked analysis of the include identifying the order to assist with order to assist when. The DON would expect an uring to be done. A bladder incontinement of provided. R28 was admitted words and the for the impaired mobility, order and risk for skine. R28's admission Mirassessment dated 7 indwelling Foley catheder. R28's admission Mirassessment dated 7 indwelling Foley catheder. Fan assessment dated 7 indwelling catheter. Fan assessment for uring ongoing use of a fole evidence of review or indwelling catheter, and corresulting from the use catheter. The physician orders R28's foley catheter on the 24th and as restricts. 	ne CAA was incomplete and ne urinary incontinence to ne type of incontinence in developing appropriate on 6/9/16, at 12:28 p.m. the OON) was unable to locate a t and indicated they do not do uld not identify when she nary incontinence assessment ince policy was requested but with an indwelling Foley plan dated 4/13/16, identified use of the catheter was pronic pain, chemotherapy	F 31	· · ·	dit	

Facility ID: 00365

If continuation sheet Page 15 of 20

		AND HUMAN SERVICES	Γ	F	TED: 07/11/2016 ORM APPROVED NO. 0938-0391
-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X:) DATE SURVEY COMPLETED
		245315	B. WING		06/09/2016
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
TRIMON	THEALTH CARE CEN	NTER		03 BROADWAY AVENUE SOUTH RIMONT, MN 56176	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From pa catheter.	age 15	F 315		
F 371 SS=F	(DON) confirmed F urinary assessmen for the ongoing use stated the closest r the Foley catheter w foley catheter she of 483.35(i) FOOD PF STORE/PREPARE The facility must - (1) Procure food fro considered satisfac authorities; and	ROCURE, /SERVE - SANITARY om sources approved or ctory by Federal, State or local distribute and serve food	F 371		7/8/16
	by: Based on observative review the facility factorial tensils were clean This had the potentive residing in the facility Findings include: On 6/8/16, at 8:30 at was observed to pri- dishwasher. The ware registered 100 deg	NT is not met as evidenced tion, interview and document ailed to assure dishes and red under sanitary conditions. tial to affect all 23 residents ity. a.m. the dietary manager (DM) rocess dirty dishes through the ash water temperature rees Fahrenheit. The DM nother load of dishes through		Corrective action - dishwasher repair Dietary staff instructed on recording temperature, what the appropriate temperature should be and when to ne maintenance and Dietary Manager if machine is not functioning at the correc- temperature. Dishwasher Policy and Procedure revised to reflect manufacturer's guidelines. Dietary Manager to audit temp log she to make sure that temps are being log	otify ect

Facility ID: 00365

If continuation sheet Page 16 of 20

STATEMENT	OF DEFICIENCIES OF CORRECTION	KANDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY PLETED
		245315	B. WING		06/	09/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00,	00/2010
TRIMON	T HEALTH CARE CEI	NTER		303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 371	was noted to be rep Fahrenheit. On 6/8/16, at 11:00 dishes was washed dishwasher and the time registered 100 6/8/16, at 12:25 p. 118 degrees. On 6 temperature did not than 100 degrees f dishes were observed dishwasher. With pushed the fill butto load. The temperative degrees Fahrenheit verified by dietary at Review of the temp and 6/16, identified breakfast wash cyco degrees Fahrenheit months. The wash and supper were m degrees all but 5 tim During interview or identified the dishw sanitation unit. She be over 120 degrees temperatures were usually warmed up She stated they we the machine but sta doesn't change the had brought this is director in 3/16 or 4	The wash temperature again gistered at 100 degrees 0 a.m. another load of soiled d via the automated e water temperature at this 0 degrees Fahrenheit. On m. the wash temperature was 5/9/16, at 8:48 a.m. the wash tregister a temperature higher Fahrenheit. Two loads of ved to be run through the each of these loads, staff on several times with each ture still did not go above 100 it. These temperatures were aide (DA)-A. berature logs for 4/16, 5/16. I that temperatures for the cle was at or above 120 it 12 times during the past 3 in temperatures for the lunch heasured at or above 120	F 37	and that the temps are appropria on manufacturer's recommendat This issue will be reviewed at mo Safety meeting and quarterly Qu Assurance meeting.	ions. nthly	

If continuation sheet Page 17 of 20

	-	AND HUMAN SERVICES				FORM	07/11/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245315	B. WING			06/0	09/2016
NAME OF F	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TRIMON	T HEALTH CARE CEN	ITER		-	03 BROADWAY AVENUE SOUTH RIMONT, MN 56176		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	Continued From pa should be over 120 During interview wit 6/9/16, at 8:55 a.m. fill several times. W and the temperature guess I will have to A review of the dish provided by the faci operating temperature a minimum of 120 of wash cycle. 483.75(o)(1) QAA COMMITTEE-MEM QUARTERLY/PLAN A facility must main assurance committe nursing services; a facility; and at least facility is staff. The quality assess committee meets an issues with respect and assurance active develops and imple action to correct ide A State or the Secret except insofar as su	ge 17 degrees Fahrenheit. th the maintenance director on he stated they have to hit the l'hen informed this did not work e remained low, he stated, "I look into it." machine product detail sheet ility identified that the ure for the machine should be degrees Fahrenheit for the IBERS/MEET NS tain a quality assessment and ee consisting of the director of physician designated by the 3 other members of the ment and assurance t least quarterly to identify to which quality assessment vities are necessary; and ements appropriate plans of entified quality deficiencies.	F 3				7/8/16
	Good faith attempts	s by the committee to identify					

If continuation sheet Page 18 of 20

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/11/2016 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245315	B. WING			06/0	09/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TRIMONT HEALTH CARE CENTER			-	03 BROADWAY AVENUE SOUTH RIMONT, MN 56176			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	a basis for sanction This REQUIREMEN by: Based on interview facility failed to ensu- and assurance (QA required and mainta- had the potential to in the facility. Findings include: Review of the qualita- attendance logs fro- the facility QAA com- and no further evide held during this time. The medical director quality assurance m During interview on director of nursing (every 3 months but only one attendance in the meeting. The in her role and the 3 meeting she had att there had been no a were reviewed and/ identified informatio The DON indicated director. The DON i	deficiencies will not be used as s. AT is not met as evidenced and document review, the ure the quality assessment A) committee met quarterly as ained required members. This affect all 21 residents residing by assurance meeting m 6/9/15 to 6/9/16, identified mittee met once on 3/23/16 ence provided of meetings e period. br did not attend the quarterly neeting held 3/23/16. 6/9/16, at 3:30 p.m. the DON) explained the QAA met acknowledged there was e record of staff participating DON explained she was new 8/16 meeting was the first tended. The DON verified action plans from 2015 that or continued in 2016. The n was not available for review. there was also a new medical ndicated there were 3 administrators in the	F 5	520	Corrective action - Re-develop a Q Assessment and Assurance commi Policy and procedure developed to address committee requirements ar purpose of committee. DON to set meeting dates, times, agendas and to notify committee members of meeting info. Committee members will be respon for conducting surveys, audits, assessments, etc. to determine the cause of issues that are brought for the committee and to work as a teat develop interventions to address the and report the effectiveness of the interventions. Education provided regarding P & P To ensure ongoing compliance, min and member signature of attendance sheet to be completed with each me Administrator to monitor QA & A sys quarterly by attending meetings and reviewing content of materials discu- at meeting in relation to meeting committee's purpose and goals.	ttee. nd sible root th to m to e issue o. stem d	
	administrative role of	during the past year.					

If continuation sheet Page 19 of 20

CENTERS FOR MEDICARE & MEDICAID SERVICES				APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE	E SURVEY PLETED
245315	B. WING _		06/0	09/2016
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		
TRIMONT HEALTH CARE CENTER		303 BROADWAY AVENUE SOUTH		
		TRIMONT, MN 56176		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520 Continued From page 19 A quality assurance policy/procedure was requested but not provided.	F 52			

Facility ID: 00365

If continuation sheet Page 20 of 20

PRINTED: 07/11/2016

STATEMENT OF DEFICIENCIES (X) PROVIDERSUPPLIERLAL DOWNERSUPPLIERLAL DOWNERSUPPLIER 06/08/2016 NAME OF PROVIDER OR SUPPLIER 245315 STITEMENT ACADESS. CITY, STATE, ZIP CODE 06/08/2016 TRIMONT HEALTH CARE CENTER STITEMENT OF DEFICIENCIES STITEMENT OF DEFICIENCIES 06/08/2016 PREFIX StiTATAL COMMENTS TERMENT OF DEFICIENCIES DEFICIENCIES CRONDUCT, NI STATE STITEMENT OF DEFICIENCIES PREFIX StiMate of PROVIDER OF DEFICIENCIES DEFICIENCY CRONDUCT, NI STATE CRONDUCT, NI STATE YAG 00 INITIAL COMMENTS FIRE SAFETY PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE COMPLEX VIESDARTURE AT THE BOTTOM OF THE FIRST PAGE OF TOR SHOULD BE CONTRUCT OF COMPLIANCE UPON THE DEFARTMENTS ACCEPTANCE. YOUR K 000 NOTITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED OF ALLEANCE UPON THE BE CONDUCTED OF ALLEANCE UPON THE SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS DEEN ATTAINED IN ACCORPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED OF ALLEANCE WITH THE REGULATIONS HAS DEEN ATTAINED IN ACCORPLICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Fublic Safety, State Fire Marshal Division on June 08, 2016. At the time of this survey, Timont Health Care Center was found not to be insubstantial compliance in MedicareMedicaid 42 CFR, Subpart 432, CFR, Subpart 433, 70(a), Life Safety from Fire, and the 2000 edition on National Fire			AND HUMAN SERVICES & MEDICAID SERVICES		F5315025 0	FORM APPROV MB NO. 0938-03
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE TRIMONT HEALTH CARE CENTER 33 BROADWAY AVENUE SOUTH PAUL SUMMARY STATEMENT OF DEFICIENCIES PAUL SUMMARY STATEMENT OF DEFICIENCIES PRETX REQUILATORY OR LSC IDENTIFYING INFORMATION) IK 000 INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUN DEPARTMENT'S ACCEPTANCE. YOUN THE DEPARTMENT'S ACCEPTANCE. YOUR UPON RECEIPT OF AN ACCEPTANCE. YOUR UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSUTE REVISITO FOY OUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTATIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesoid Steffy from Fire, and the 2000 edition of National Fire Protoction Association Meeting 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 At 5 Minnesoid Steed, Suit 145 St. Paul, MN S5101-5145, or				1 ' '		
TRIMONT HEALTH CARE CENTER 303 BROADWAY VACUUE SOUTH TRIMONT, MM 66176 (Y4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BEPRECEDED BY FULL TAG D PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) COMPLETE (EACH CORRECTIVE DEFICIENCY) COMPLETE (EACH CORRECTIVE DEFICIENCIES) COMPLETE (EACH CORRECTIVE D			245315	B. WING		06/08/2016
PREFX TAG (EACH DEFICIENCY MAY BE DEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFX TAG (EACH CORREPT DE ADPRODUCTIVE ACTION SHOULD BE CROSS-REFERENCED TO TIME ADPRODURATE DEFICIENCY) 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 SIGMATURE 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 ONSTE 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 June 08, 2016. At the time of this survey, Trimont Health Care Center was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid 442 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFFA) 101 Life Safety Code (LSC), Chapter 19 Existing 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 Street, Suite 145 St. Paul, MN 55101-5145, or			ITER		303 BROADWAY AVENUE SOUTH	
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 June 08, 2016. At the time of this survey, Timmont Health Care Center was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections Mather Fire Marshal Division	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLETI
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 June 08, 2016. At the time of this survey, Trimont Health Care Center was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	INITIAL COMMEN	TS	K 00	00	
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 June 08, 2016. At the time of this survey, Timon Health Care Center was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety Code (LSC), Chapter 19 Existing 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 Street, Suite 145 st. Paul, MN 55101-5145, or		FIRE SAFETY				
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 June 08, 2016. At the time of this survey, Trimont Health Care Center was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or		ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 FORM WILL BE			
Minnesota Department of Public Safety, State Fire Marshal Division, on June 08, 2016. At the time of this survey, Trimont Health Care Center was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or		ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN			
CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or		Minnesota Departn Fire Marshal Division time of this survey, was found not to be with the requirement Medicare/Medicaid 483.70(a), Life Safe edition of National (NFPA) 101 Life Safe	nent of Public Safety, State on, on June 08, 2016. At the Trimont Health Care Center e in substantial compliance nts for participation in at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association afety Code (LSC), Chapter 19			
State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or		CORRECTION FO DEFICIENCIES (K	R THE FIRE SAFETY -TAGS) TO:		FPOC	
By email to:		State Fire Marshal 445 Minnesota Stre	Division eet, Suite 145			
		By email to:				

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.

TATEMEN	OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION - MAIN BUILDING 01	(X3) DA	. 0938-039 TE SURVEY MPLETED
		245315	B. WING		06/08/2016	
	PROVIDER OR SUPPLIER T HEALTH CARE CE		STREET ADDRESS, CITY, STATE, ZIP CODE 303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIOI DATE
K 000	Angela.Kappenma <mailto:angela.ka THE PLAN OF CC DEFICIENCY MUS FOLLOWING INFO 1. A description of to correct the defice 2. The actual, or p 3. The name and/or responsible for com- prevent a reoccurr Trimont Healthcard follows: The original buildin one-story, has a p- sprinklered and wa II(222) constructio The 1992 Chapel / basement, is fully determined to be of The facility has a f detection in the co- corridors which is department notific equipped with sing smoke alarms. Th beds and had a co- survey.</mailto:angela.ka 	state.mn.us hitney@state.mn.us> and hitney@state.mn.us ppenman@state.mn.us> DRRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION: what has been, or will be, done ciency. roposed, completion date. or title of the person rrection and monitoring to rence of the deficiency. e Center was constructed as ng was constructed in 1963, is artial basement, is fully as determined to be of Type n; Addition is one-story, has no sprinklered and was of Type V(111) construction. ire alarm system with smoke with smoke ple-station, battery-operated he facility has a capacity of 36 ensus of 23 at time of the at 42 CFR, Subpart 483.70(a) is	K 000			

Facility ID: 00365

If continuation sheet Page 2 of 21

2

	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA				0938-039 E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	· · ·	01 - MAIN BUILDING 01		IPLETED	
		245315	B. WING		06/	08/2016	
NAME OF	PROVIDER OR SUPPLIER	۲		TREET ADDRESS, CITY, STATE, ZIP CODE			
	T HEALTH CARE CE	INTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE	
K 021 SS=E	Doors in an exit p horizontal exit, sm enclosure are self position, unless he complying with 7.2 all such doors thre compartment or e (a) The required r (b) Local smoke of smoke passing th smoke detection s (c) The automatic 18.2.2.2.6, 18.3.1 7.2.1.8.2 Door assemblies approved type wit rating. 8.2.3.2.3.1 Boiler rooms, hea equipment rooms This STANDARD Doors in an exit p enclosure, horizon hazardous area e kept in the closed as release device automatically close the smoke compa activation of: (a) The required r (b) Local smoke of smoke passing th smoke detection s (c) The automatic	sprinkler system, if installed .2, 19.2.2.2.6, 19.3.1.2, in vertical openings are of an h appropriate fire protection ter rooms, and mechanical doors are kept closed. is not met as evidenced by: passageway, stairway ntal exit, smoke barrier or nclosure are self-closing and position, unless held open by complying with 7.2.1.8.2 that ses all such doors throughout artment or entire facility upon manual fire alarm system and detectors designed to detect rough the opening or a required	K 021	Contacted electrician to wire mag hold open device to fire alarm syst Proposed date of completion 7/15/ Maintenance Director to monitor for completion.	em. ′16.	7/15/16	

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTH		D. 0938-039 TE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	. ,		MPLETED
		245315	B. WING	0	6/08/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
rrimon [.]	F HEALTH CARE CEI	NTER		303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
K 021	Continued From pa	_	K 02	1	
	approved type with rating. 8.2.3.2.3.1	appropriate fire protection			
		er rooms, and mechanical doors are kept closed.			
	FINDINGS INCLUDE:				
	6:30pm, observation Serving Door was of magnetic hold open	ween the hours of 9:00am to on revealed the Kitchen observed being held open by a n device that is not connected stem that would release the m activation.			
K 022 SS=E	supervisor at the ti NFPA 101 LIFE SA	erified with the maintence me of discovery. \FETY CODE STANDARD	K 02	2	6/20/16
33-E	Access to exits sha readily visible signs way to reach exit is occupants. Doors, not a way of exit th an exit have a sign 7.10, 18.2.10.1, 19				
	Access to exits sh readily visible signs way to reach exit is occupants. Doors, not a way of exit th	is not met as evidenced by: all be marked by approved, s in all cases where the exit or s not readily apparent to the passages or stairways that are at are likely to be mistaken for designating "No Exit". 0.2.10.1		The door from the Dining Room to Courtyard has been labeled as "No Exit" and the "No Exit" sign at the Chapel exit door has been removed. Maintenance Director to ensure signage remains in place.	
	FINDINGS INCLU	DE			
	On 06/08/2016 bet 6:30pm, observatio	ween the hours of 9:00am to			

		& MEDICAID SERVICES			0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED 06/08/2016	
		245315	B. WING			
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	T HEALTH CARE CEN	ITER		303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
K 022	Continued From pa	age 4	K 022	2		
	considered as a ex labeled "No Exit" a	Courtyard is not being it and therefore it should be nd the Chapel Exit Door is nd therefore the "No Exit" sign ed.				
K 029 SS=F	supervisor at the ti NFPA 101 LIFE SA	erified with the maintence me of discovery. FETY CODE STANDARD construction (with o hour	K 029	9	7/15/16	
	extinguishing syste and/or 19.3.5.4 pro- the approved autor option is used, the other spaces by sn doors. Doors are s field-applied protect 48 inches from the permitted. 19.3.2 This STANDARD One hour fire rate fire-rated doors) or extinguishing syste	an approved automatic fire em in accordance with 8.4.1 stects hazardous areas. When matic fire extinguishing system areas are separated from noke resisting partitions and self-closing and non-rated or etive plates that do not exceed bottom of the door are 2.1 is not met as evidenced by: d construction (with o hour an approved automatic fire em in accordance with 8.4.1 otects hazardous areas. When		01) O2 room door - closure installed on the door by maintenance on 6/30/16.		
	the approved autor option is used, the other spaces by sr doors. Doors are field-applied protect	matic fire extinguishing system areas are separated from noke resisting partitions and self-closing and non-rated or ctive plates that do not exceed bottom of the door are		02) Wooden wedge was removed from holding open the kitchen storage room door. Completed 6/21/16. Maintenance Director directed dietary staff not to use the wedge to hold the door open.		
	permitted. 19.3. FINDINGS INCLU			03) Housekeepers Cart room door - closure to be installed on the door by 7/15/16. Wall penetrations were sealed or 6/21/16.	n	
	between 09:00 AN	pection on June 08, 2016, I and 6:30 PM, observation on revealed the following		04) Generator room door - latch repaired on 6/28/16 by maintenance.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/01/2016 FORM APPROVED OMB NO. 0938-0391

		E & MEDICAID SERVICES				1	0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245315	B. WING	_		06/0	08/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
TRIMON	T HEALTH CARE CE	NTER			03 BROADWAY AVENUE SOUTH RIMONT, MN 56176		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
K 029	 01.) The oxygen si hallway was obser device on the door 02.) The kitchen si observed being he 03.) The housekee observed without a door and wall penetration of the generator being able to positiand wall penetration of the door on the door of the door on the door of the kitchen was observed without a door. 09.) Wall penetrating generator room ar electrical conduit the kitchen was observed. 10.) The door on the kitchen was observed without a door. 09.) Wall penetrating generator room ar electrical conduit the kitchen was observed. 11.) Penetrations are electrical conduit the kitchen was observed. NOTE: All Hazard to ensure compliant. 	Hazardous Areas: torage room door in the south ved without a self closing torage room door was add open with a wooden wedge. epers cart room door was a self closing device on the etrations around cables not r room door was observed not ively latch into the door frame ons not properly sealed. Ace access door in the boiler ed being held open by a wire. Tooms were observed not properly r room. The old incinerator room was g able to positively latch into the boom/storage room was a self closing device on the ions into the corridor from the ound the Ip gas line and was observed without being the ventilator/storage room in observed without a self closing around fire sprinkler pipe and was observed in the chapel ous Areas need to be checked nce.	KO	29	 05) Crawl space access door - wir was holding door open was remove maintenance on 6/21/16. 06) Wall penetrations in boiler root sealed by maintenance on 6/28/16 07) Door on old incinerator room - be repaired so it positively latchest door frame by maintenance by 7/2 08) Old salt room/storage room - to be installed by maintenance by 09) Wall penetrations were sealed maintenance 6/21/16. 10) Door on ventilator/storage root kitchen - closure to be installed by maintenance by 7/15/16. 11) Penetrations around sprinkler and electrical conduit in chapel mechanical room was sealed on 6 All hazardous areas maintained by Maintenance Director. 	ved by m were 5. door to into the 15/16. closure 7/15/16. d by om in / pipe 6/23/16.	
	These deficient pr Maintenance Dire	actices were observed by the ctor.					

FORM CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 6 of 21

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

PRINTED: 07/01/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	SFOR MEDICARE	& MEDICAID SERVICES			NUD NO.	0920-0291
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		E SURVEY PLETED
		245315	B. WING		06/0	08/2016
	ROVIDER OR SUPPLIER	ITER	STREET ADDRESS, CITY, STATE, ZIP CODE 303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 033 SS=E	Exit enclosures (su with construction ha at least one hour, a continuous path of against fire or smol building. 7.1.3.2, 8.1 This STANDARD is Exit enclosures (su with construction ha at least one hour, a continuous path of protection against f of the building. 7.1. FINDINGS INCLUE During Facility Insp between 09:00 AM	FETY CODE STANDARD ch as stairways) are enclosed aving a fire resistance rating of re arranged to provide a escape, and provide protection ke from other parts of the 2.5.2, 8.2.5.4, 19.3.1.1 s not met as evidenced by: uch as stairways) are enclosed aving a fire resistance rating of re arranged to provide a escape, and provide ire or smoke from other parts 3.2, 8.2.5.2, 8.2.5.4, 19.3.1.1 DE: ection on June 08, 2016, and 6:30 PM, observation on revealed the following	K 03	 01) Door on the timecard stairwe have closure installed by mainten 7/15/16. 02) Wall penetrations in SW stair sealed by maintenance on 6/23/1 Both discrepancies to be monitor Maintenance Director. 	ance by well 6.	7/15/16
K 034 SS=E	observed not being frame. 02.) Wall penetratic southwest stairwell These deficient pra Maintenance Direc NFPA 101 LIFE SA Stairways and smo exits are in accorda 18.2.2.4, 19.2.2.3, This STANDARD in Stairways and smo	FETY CODE STANDARD keproof enclosures used as ance with 7.2. 18.2.2.3, 19.2.2.4 s not met as evidenced by: okeproof enclosures used as ance with 7.2. 18.2.2.3,	K O	34 Handrail was installed within the descending side of the SW stairv maintenance on 6/28/16.	vell by	6/28/16

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DGKY21

Facility ID: 00365

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO.		
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` ′			E SURVEY PLETED	
		245315	B. WING		06/0	06/08/2016	
NAME OF F	PROVIDER OR SUPPLIER		· · · · · ·	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	T HEALTH CARE CEN	ITER	303 BROADWAY AVENUE SOUTH				
				TF	RIMONT, MN 56176		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE	
K 034	Continued From pa	-	К 0	34	Handrails to be maintained by		
	FINDINGS INCLUE	DE:			maintenance.		
	between 09:00 AM	ection on June 08, 2016, and 6:30 PM, observation on revealed the following					
	No handrail was ob side on the southw	served within the descending est stairwell exit.					
	Maintenance Direc		-				
K 047 SS=E		FETY CODE STANDARD	KO	47		7/15/16	
	accordance with 7.	signs are displayed in 10 with continuous illumination emergency lighting system. 1					
	with less than 30 of travel is obvious.)	e story existing occupancies ccupants where the line of exit s not met as evidenced by:					
	Exit and directiona accordance with 7.	I signs are displayed in 10 with continuous illumination emergency lighting system.		1	01) Illuminated exit signs placed at N & S exits from dining room by maintenance on 6/22/16.		
	(Indicate N/A in one	e story existing occupancies ccupants where the line of exit			02) Illuminated exit signs placed from kitchen into dining room and exit from kitchen near freezer by maintenance on 6/22/16.		
	FINDINGS INCLU	DE					
	between 09:00 AM	ection on June 08, 2016, and 6:30 PM, observation on revealed the following			03) Illuminated exit from lower level to timecard stairwell to be placed by maintenance by 7/15/16.		
	discrepancies:	ns were not observed in the			04) Illuminated exit from lower level to SW stairwell to be placed by 7/15/16 by maintenance.		

Facility ID: 00365

PRINTED: 07/01/2016

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTIPLI		IB NO. 0938-03 (X3) DATE SURVEY		
	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01 - MAIN BUILDING 01	COMPLETED		
		245315	B. WING	06/08/2016			
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE			
TRIMON	T HEALTH CARE CE	NTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	LD BE COMPLETI		
K 047	Continued From pa	age 8	K 047				
	02.) Exit from the l and the exit from the 03.) Exit from the l stairwell.	th exits from the dining room, kitchen into the dining room ne kitchen near the freezer ower level to the time card ower level to the southwest		Maintenance of illuminated exits to maintained and monitored by the Maintenance Director.	be		
K 050 SS=E	Maintenance Direc	actices were observed by the ctor. AFETY CODE STANDARD	K 050		6/29/16		
	signal and simulatic conditions. Fire dri times under varyin on each shift. The and is aware that or routine. Responsitic conducting drills is persons who are or Where drills are or 6:00 AM a coded a instead of audible 18.7.1.2, 19.7.1.2 This STANDARD Fire drills include signal and simulatic conditions. Fire dri times under varyin on each shift. The and is aware that a routine. Responsitic conducting drills is persons who are of Where drills are of	is not met as evidenced by: the transmission of a fire alarm ion of emergency fire ills are held at unexpected g conditions, at least quarterly staff is familiar with procedures drills are part of established bility for planning and assigned only to competent qualified to exercise leadership. bonducted between 9:00 PM and announcement may be used		Quarterly fire drills will be conducted varied times on varied shifts. Fire of will be documented by the Mainten Director and the Administrator will randomly audit the documentation compliance.	drills ance		

Facility ID: 00365

If continuation sheet Page 9 of 21

		AND HUMAN SERVICES & MEDICAID SERVICES		-	FORM	07/01/2016 APPROVED 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DAT	E SURVEY PLETED
		245315	B. WING		06/	08/2016
NAME OF F	PROVIDER OR SUPPLIER		L	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
TRIMON	T HEALTH CARE CEN	ITER		303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 050	Continued From pa	-	K 05	0		
	During Facility Insp between 09:00 AM review revealed qu not being conducte the year:	ection on June 08, 2016, and 6:30 PM, documentation arterly fire drills were observed d at varied times throughout		•		
	@12:51pm and 2nd Evening shift (3pm	n) 1st quarter fire drill d quarter fire drill @ 1:04pm. -11pm) 1st quarter fire drill @ ıarter fire drill @ 4:50pm.				
K 051 SS=D	Maintenance Direc	actices were observed by the tor. FETY CODE STANDARD	K 05	1		7/15/16
	components appro accordance with Ni and NFPA 72, Nation provide effective we building. Fire alarm transmission paths Initiation of the fire means and by any alarm, detection de Manual alarm boxe egress near each re boxes in patient slar required at exits if located at all nurse notification is provi- signals. In critical of sufficient. The fire alarm automaticall the event of fire. The activates required	a is installed with systems and ved for the purpose in FPA 70, National Electric Code onal Fire Alarm Code to arning of fire in any part of the n system wiring or other a are monitored for integrity. alarm system is by manual required sprinkler system evice, or detection system. es are provided in the path of required exit. Manual alarm eeping areas shall not be manual alarm boxes are s's stations. Occupant ded by audible and visual care areas, visual alarms are alarm system transmits the y to notify emergency forces in he fire alarm automatically control functions. System ained and readily available.				

ATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY
	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING	01 - MAIN BUILDING 01		
		245315	B. WING			8/2016
IAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODI		
RIMON	T HEALTH CARE CEN	NTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
K 051	A fire alarm system components appro- accordance with NI and NFPA 72, Natio provide effective was building. Fire alarm transmission paths Initiation of the fire means and by any alarm, detection de Manual alarm boxe egress near each r boxes in patient sle required at exits if located at all nurse notification is provis signals. In critical of sufficient. The fire alarm automatically the event of fire. Th activates required	age 10 s not met as evidenced by: n is installed with systems and ved for the purpose in FPA 70, National Electric Code onal Fire Alarm Code to arning of fire in any part of the n system wiring or other are monitored for integrity. alarm system is by manual required sprinkler system evice, or detection system. es are provided in the path of required exit. Manual alarm eeping areas shall not be manual alarm boxes are t's stations. Occupant ded by audible and visual eare areas, visual alarms are alarm system transmits the y to notify emergency forces in ne fire alarm automatically control functions. System ined and readily available.	K 051	Staff on-call sleeping area in I will have a smoke detector ins connected into the main fire al sounder board by 7/15/16. Ma Director to monitor for complia installation	talled that is arm with a aintenance	
During betwe during discre The s was o conne withou	between 09:00 AM	pection on June 08, 2016, and 6:30 PM, observation				5
	discrepancy: The staff on-call sl was observed with connected into the	on revealed the following eeping area in the lower level out a smoke detector main fire alarm system and board in the immediate area.				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	E CONSTRUCTION		SURVEY	
ID PLAN O	FCORRECTION	DENTIFICATION NUMBER:	A BUILDING	01 - MAIN BUILDING 01	COMPLETED		
		245315	B. WING		06/08/2016		
AME OF F	PROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
	T HEALTH CARE CE	NTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE	
K 051	Continued From pa	age 11	K 051				
	Maintenance Direc		14.050			7/45/40	
K 053 SS=E	NFPA 101, 483.70 STANDARD	(a)(7) LIFE SAFETY CODE	K 053			7/15/16	
	(dining rooms, acti rooms, etc) are to battery-operated s a testing, maintena program to ensure 483.70(a)(7) This STANDARD In an existing nurs the resident sleepi (dining rooms, acti rooms, etc) are to battery-operated s a testing, maintena	ng rooms and public areas vity rooms, resident meeting be equipped with single station moke detectors. There will be ance and battery replacement proper operation. 42 CFR is not met as evidenced by: sing home, not fully sprinklered, ng rooms and public areas vity rooms, resident meeting be equipped with single station moke detectors. There will be ance and battery replacement proper operation. 42 CFR		Smoke detector in the Media Center tested and battery replaced on 6/30/ This battery operated smoke detector be replaced with a smoke detector t will be connected into the main fire a system by 7/15/16. Installation and monitoring of compliance will be completed by the Maintenance Direct	'16. or will hat alarm		
	FINDINGS INCLU	DE:					
	between 09:00 AN documentation rev battery operated s	bection on June 08, 2016, 1 and 6:30 PM, during view it was revealed that the moke detector in the media ted January through May 2016.					
K OF C	Maintenance Direct		K 054			6/27/16	
K 054 SS=E	NEPA TUT LIFE S/	AFETY CODE STANDARD	r U94			5/2//10	
		e detectors, including those d-open devices, are approved,					

ATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		CONSTRUCTION (1 - MAIN BUILDING 01	X3) DATE COMP	SURVEY LETED	
		245315	B. WING 06			06/0	08/2016	
	ROVIDER OR SUPPLIER	ITER	STREET ADDRESS, CITY, STATE, ZIP CODE 303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176					
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETIO DATE	
K 054	054 Continued From page 12 maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 FINDINGS INCLUDE:		К 0	54	Corridor smoke detector near room was moved for easier accessibility for testing. Maintenance Director to monitor tes smoke detector.	or		
К 056	between 09:00 AM documentation rev inspection/smoke of revealed that the c room 105 was not unaccessible with if fire sprinkler pipe. This deficient pract Maintenance Supe	ection on June 08, 2016, and 6:30 PM, during iew of the annual fire alarm detector sensitivity report it was orridor smoke detector near tested due to being ts location directly above the tice was verfied by the rivisor.	ĸ)56			7/15/16	
SS=E	Where required by facilities shall be p approved, supervis- in accordance with systems are equip switches which are the building fire ala construction, altern shall be permitted protection in speci- regulations prohibi NPFA 13 This STANDARD Where required b	section 19.1.6, Health care rotected throughout by an sed automatic sprinkler system section 9.7. Required sprinkler ped with water flow and tamper e electrically interconnected to arm. In Type I and II native protection measures to be substituted for sprinkler fic areas where State or local t sprinklers. 19.3.5, 19.3.5.1, is not met as evidenced by: y section 19.1.6, Health care rotected throughout by an			01) Items stored on fire sprinkler p maintenance office removed on 6/2	bipe in 27/16.		

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OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
245315	IDENTIFICATION NOMBER.		E CONSTRUCTION 01 - MAIN BUILDING 01	COMF	PLETED
	245315	B. WING		06/08/2016	
PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
T HEALTH CARE CEI	NTER		03 BROADWAY AVENUE SOUTH RIMONT, MN 56176		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
Continued From pa	age 13	K 056			
in accordance with systems are equip	section 9.7. Required sprinkler ped with water flow and tamper		items are not placed on sprinkler pi the future.	ipes in	
switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13	rm. In Type I and II native protection measures to be substituted for sprinkler		02) Sprinkler head at top of dirty lin chute to be replaced by Simplex by 7/15/16.	en ′	
During Facility Insp	pection on June 08, 2016,				
between 09:00 AM	I and 6:30 PM, the following		installation is completed - Simplex	has	
being stored direct pipe in the Mainter 02.) The fire sprint linen chute was ob 03.) A fire sprinkle storage closet in th 04.) A fire sprinkle	tly on top of the fire sprinkler hance Supervisor Office. kler head at the top of the dirty bserved being corroded. r head was not observed in the he kitchen. r head was not observed in the		installation.		
Maintenance Supe NFPA 101 LIFE S/	ervisor.	K 062			6/22/16
Required automat continuously main condition and are	tained in reliable operating inspected and tested				
	SUMMARY ST/ (EACH DEFICIENC REGULATORY OR I in accordance with systems are equip switches which are the building fire ala construction, alterr shall be permitted protection in specif regulations prohibi NPFA 13 FINDINGS INCLU During Facility Insy between 09:00 AM deficiencies were of sprinkler system: 01.) Items (light bu being stored direct pipe in the Mainter 02.) The fire sprinkle storage closet in th 04.) A fire sprinkle storage closet in th 05.) The sprinkle storage closet in th 04.) A fire sprinkle storage closet in th 05.) The sprinkle storage closet in th 05.) The sprinkle	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 FINDINGS INCLUDE: During Facility Inspection on June 08, 2016, between 09:00 AM and 6:30 PM, the following deficiencies were observed related to the fire sprinkler system: 01.) Items (light bulbs/wood) were observed being stored directly on top of the fire sprinkler pipe in the Maintenance Supervisor Office. 02.) The fire sprinkler head at the top of the dirty linen chute was observed being corroded. 03.) A fire sprinkler head was not observed in the storage closet in the kitchen. 04.) A fire sprinkler head was not observed in the storage closet in the dining room. These deficient practices were verfied by the Maintenance Supervisor. NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25,	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 13 in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 FINDINGS INCLUDE: During Facility Inspection on June 08, 2016, between 09:00 AM and 6:30 PM, the following deficiencies were observed related to the fire sprinkler system: 01.) Items (light bulbs/wood) were observed being stored directly on top of the fire sprinkler pipe in the Maintenance Supervisor Office. 02.) The fire sprinkler head at the top of the dirty linen chute was observed being corroded. 03.) A fire sprinkler head was not observed in the storage closet in the kitchen. 04.) A fire sprinkler head was not observed in the storage closet in the dining room. These deficient practices were verfied by the Maintenance Supervisor. NFPA 101 LIFE SAFETY CODE STANDARD K 062 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PREFIX (EACH ODERCETIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPH DEFICIENCY) Continued From page 13 in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 K 056 FINDINGS INCLUDE: 02) Sprinkler head to be install simplex in the storage closet in the kitchen by 7/15/16. 03) Fire sprinkler head to be install the storage closet in the dining roo Simplex by 7/15/16. During Facility Inspection on June 08, 2016, between 09:00 AM and 6:30 PM, the following deficiencies were observed related to the fire sprinkler system: 04) Fire sprinkler head to be install the storage closet in the dining roo Simplex by 7/15/16. 01.) Items (light bulbs/wood) were observed being stored directly on top of the fire sprinkler pipe in the Maintenance Supervisor Office. K 062 02.) The fire sprinkler head was not observed in the storage closet in the kichen. K 062 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. K 062 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. K 062	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFX TAG PREFX PROPERTY EVAN OF CORRECTION (EACH CORRECTURE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 13 in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire atarm. In Type 1 and II construction, alteramitive protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 K 056 FINDINGS INCLUDE: 02) Sprinkler head to be installed for incise were observed being stored directly on top of the fire sprinkler system: 03) Fire sprinkler head to be installed in the storage closet in the dining room by Simplex by 7/15/16. 01) Items (light bulbs/wood) were observed being stored directly on top of the fire sprinkler pipe in the Maintenance Supervisor. 04) Fire sprinkler head to be installed in the storage closet in the dining room. These deficient practices were verified by the Maintenance Supervisor. K 062 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. K 062

Event ID: DGKY21 Facility ID: 00365

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TPLE CONSTRUCTION		E SURVEY PLETED	
				NG UT - MAIN BUILDING UT			
		245315				08/2016	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
	T HEALTH CARE CEN	ITER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176				
	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	IX (EACH CORRECTIVE ACTION SHOULD BE		COMPLÉTIO DATE	
K 062	Continued From pa	age 14	KO	62			
		ained in reliable operating	IX U	put back in place on 6/22/16			
	condition and are ir	inspected and tested (.6, 4.6.12, NFPA 13, NFPA 25,		Maintenance Director to ens placement of tiles is appropr	ure that		
	FINDINGS INCLUE	DE					
	between 09:00 AM	ection on June 08, 2016, and 6:30 PM, the following bserved related to the fire					
	the media center.T	tiles were observed missing in hese missing ceiling tiles will e operation of the nearby fire					
	Maintenance Supe						
K 064 SS=D	NFPA 101 LIFE SA	FETY CODE STANDARD	K 0	64		6/8/16	
	inspected, and mai	uishers shall be installed, ntained in all health care ordance with 9.7.4.1, NFPA					
	18.3.5.6, 19.3.5.6						
	This STANDARD in Portable fire exting inspected, and main	s not met as evidenced by: guishers shall be installed, intained in all health care cordance with 9.7.4.1, NFPA		Fire extinguishers in laundr lower level corridor placed of 6/8/16.			
	10. 18.3.5.6, 19.3.5.6			Proper placement of exting monitored by the Maintenar			
	FINDINGS INCLU	DE:					
		ection on June 08, 2016, and 6:30 PM, the following					

Event ID: DGKY21

Facility ID: 00365

If continuation sheet Page 15 of 21

PRINTED: 07/01/2016

	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION (X3) DAT	0938-039 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:		1 - MAIN BUILDING 01	IPLETED
		245315	B. WING	06/	08/2016
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	
	HEALTH CARE CE	NTER		3 BROADWAY AVENUE SOUTH RIMONT, MN 56176	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL 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 064	Continued From p deficiency was obs	served:	K 064		
	extinguisher in the	in the laundry and a fire lower level corridor were g stored on wall hooks or fire ets.			
K 070 SS=E	Maintenance Supe	actices were verfied by the ervisor. AFETY CODE STANDARD	K 070		6/30/16
33-E	prohibited in all he it shall be permitte staff and employe elements of such degrees F (100 de 18.7.8, 19.7.8 This STANDARD Portable space he prohibited in all he it shall be permitte staff and employe elements of such degrees F (100 de 18.7.8, 19.7.8	is not met as evidenced by: eating devices shall be ealth care occupancies. Except ed to be used in non-sleeping e areas where the heating devices do not exceed 212 egrees C).		Policy was wrote that prohibits use of portable space heaters in the facility. Policy placed in facility P & P Book and in Maintenance Book and posted for all staf to read. Compliance will be monitored by the Safety Committee monthly.	
	between 09:00 AN documentation re written policy that	IDE: pection on June 08, 2016, / and 6:30 PM, during view, it was revealed that a prohibits the use of portable s available for review.			
K 072	Maintenance Dire	ctice was observed by the ctor. AFETY CODE STANDARD	K 072		6/8/16

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 01 - Main Building 01	(X3) DATE COMF	SURVEY	
		245315	B. WING		06/08/2016		
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 303 BROADWAY AVENUE SOUTH IRIMONT, MN 56176			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE	
K 072 SS=E	Continued From page 16 Means of egress shall be 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 shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1 This STANDARD is not met as evidenced by: Means of egress shall be 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 shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1.				ace any e Director		
K 074 SS=E	During Facility Insp between 09:00 AM deficiency was observing a chair was observing southwest stairwell This deficient prace Maintenance Direct NFPA 101 LIFE SA Draperies, curtains and other loosely h serving as furnishing resistant in accord shower curtains. So cubical curtains ar accordance with N	bection on June 08, 2016, I and 6:30 PM, the following served: ved being stored within the I exit. AFETY CODE STANDARD s, including cubicle curtains, hanging fabrics and films ings or decorations are flame lance with NFPA 701 except for Sprinklers in areas where e installed shall be in IFPA 13 to avoid obstruction of .1, 18.3.5.5, 19.3.5.5, 18.7.5.1,	K 07	4		7/15/16	

Event ID: DGKY21

Facility ID: 00365

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/01/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	NID NO.	0930-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245315	B. WING	S		06/0	08/2016
	ROVIDER OR SUPPLIER	ITER		30	REET ADDRESS, CITY, STATE, ZIP CODE 3 BROADWAY AVENUE SOUTH RIMONT, MN 56176		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 074	meet the char lengt specified when methods cited in 10 19.7.5.2. o Newly introduced char length and hea when tested in accord in 10.3.2 (3) and 10 o Newly introduced mattresses means This STANDARD i Draperies, curtains and other loosely h serving as furnishir resistant in accord shower curtains. Sp cubical curtains are accordance with NI the sprinkler. 10.3. 19.7.5.1, NFPA 13 o Newly introduced meet the char leng specified when methods cited in 10 19.7.5.2. o Newly introduced char length and he when tested in acc in 10.3.2 (3) and 10 o Newly introduced	d upholstered furniture shall th and heat release criteria tested in accordance with the 0.3.2 (2) and 10.3.3, 18.7.5.2, d mattresses shall meet the at release criteria specified ordance with the method cited 0.3.4. 18.7.5.3, 19.7.5.3 d upholstered furniture and purchased since March, 2003. s not met as evidenced by: s, including cubicle curtains, anging fabrics and films ngs or decorations are flame ance with NFPA 701 except for orinklers in areas where a installed shall be in FPA 13 to avoid obstruction of 1, 18.3.5.5, 19.3.5.5, 18.7.5.1, d upholstered furniture shall th and heat release criteria tested in accordance with the 0.3.2 (2) and 10.3.3, 18.7.5.2, d mattresses shall meet the at release criteria specified ordance with the method cited 0.3.4. 18.7.5.3, 19.7.5.3 d upholstered furniture and purchased since March, 2003.	K	074	Privacy curtains to be treated with Stop I retardant by 7/15/16 and ite documented when completed by t Maintenance Director. Safety Cor to ensure that curtains, draperies, hanging fabrics and films serving furnishings or decorations are flam resistant.	ms he nmittee loosely as	

FORM CMS-2567(02-99) Previous Versions Obsolete

		AND HUMAN SERVICES & MEDICAID SERVICES		FORM	07/01/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION (X3) DATE G 01 - MAIN BUILDING 01 COMI	E SURVEY PLETED
		245315	B. WING		08/2016
	PROVIDER OR SUPPLIER	ITER		STREET ADDRESS, CITY, STATE, ZIP CODE 303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 074	Continued From pa	age 18	K 07	4	
	between 09:00 AM documentation rev was no documenta	ection on June 08, 2016, and 6:30 PM, during iew, it was revealed that there tion for the privacy curtains he resident rooms to show that FPA 701,			
K 076 SS=E	Maintenance Direc NFPA 101 LIFE SA Medical gas storag	FETY CODE STANDARD le and administration areas in accordance with NFPA 99,	K 07	6	6/23/16
	3,000 cu.ft. are end separation. (b) Locations for su 3,000 cu.ft. are ver 4-3.1.1.2 (NFPA 9 18.3.2.4, 19.3.2.4 This STANDARD Medical gas stora	e locations of greater than closed by a one-hour upply systems of greater than hted to the outside. 9), 8-3.1.11.1 (NFPA 99), is not met as evidenced by: ge and administration areas in accordance with NFPA 99, h Care Facilities.		One O2 cylinder that wasn't stored properly was removed from the facility on 6/23/16. Maintenance Director to monitor storage of O2 tanks. Staff educated on	
	3,000 cu.ft. are en separation. (b) Locations for s 3,000 cu.ft. are ve 4-3.1.1.2 (NFPA 9 18.3.2.4, 19.3.2.4	e locations of greater than closed by a one-hour upply systems of greater than nted to the outside. 19), 8-3.1.11.1 (NFPA 99),		the need for O2 tanks to be stored securely.	
	FINDINGS INCLU				
	During Facility Ins	pection on June 08, 2016,			

Event ID: DGKY21

Facility ID: 00365

If continuation sheet Page 19 of 21

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE		B NO. 0938-0 X3) DATE SURVE	ΞY
D PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A, BUILDING (01 - MAIN BUILDING 01	COMPLETED	
		245315	B. WING		06/08/2016	
AME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
RIMON	T HEALTH CARE CEN	ITER	1	03 BROADWAY AVENUE SOUTH RIMONT, MN 56176		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		ETIO
K 076	Continued From pa	ae 19	K 076			
	between 09:00 AM	and 6:30 PM, one oxygen				
		erved being stored in the				
		m without being chained or k that would prevent the				
	cylinder from falling	over.				
		ice was observed by the				
K 144	Maintenance Direc NFPA 101 LIFE SA	IOF. FETY CODE STANDARD	K 144		6/30/*	16
SS=E						
		ed weekly and exercised ninutes per month and shall be				
	in accordance with	NFPA 99 and NFPA 110.				
	3-4.4.1 and 8-4.2 (1 110)	NFPA 99), Chapter 6 (NFPA				
	This STANDARD i	s not met as evidenced by:				
		ted weekly and exercised ninutes per month and shall be		Generator test report was revised t indicate cool down time. Maintenar		
	in accordance with	NFPA 99 and NFPA 110.		Director responsible to document co	loo	
	3-4.4.1 and 8-4.2 (110)	NFPA 99), Chapter 6 (NFPA		down time.		
	FINDINGS INCLU	DE:				
	between 09:00 AM documentation rev it was revealed tha	ection on June 08, 2016, and 6:30 PM, during iew, t the cool down time was not on the monthly generator test				
	This deficient pract Maintenance Direc	tice was observed by the				
K 147		FETY CODE STANDARD	K 147		6/29/	16
SS=E	Electrical wiring an	d equipment shall be in ational Electrical Code. 9-1.2				

Event ID: DGKY21

Facility ID: 00365

If continuation sheet Page 20 of 21

ATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE COMF	SURVEY PLETED
		245315	B. WING			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
K 147	Electrical wiring ar accordance with N (NFPA 99) 18.9.1, FINDINGS INCLUI During Facility Insp between 09:00 AM electrical deficienc 01.) The power str exposed wires at t 02.) The power col exposed wires at t 03.) The window a observed plugged medical records of 04.) An extension observed being us 05.) Wall conduit in room in the kitcher 06.) Power strips v source of fixed wir rooms.	 19.9.1 is not met as evidenced by: nd equipment shall be in ational Electrical Code. 9-1.2 19.9.1 DE: Dection on June 08, 2016, I and 6:30 PM, the following ies were observed: ip in Resident room 106 was he plug. rd on the kitchen freezer was he the plug. ir conditioning unit was into a power strip in the ffice. cord in the generator room was see as a source for fixed wiring. n the ventilator/mechanical n has exposed wiring. were observed being used as a ing in 18 out of 21 resident 	K 147	 01) Power strip in resident room removed on 6/28/16. 02) Power cord on kitchen freeze repaired on 6/29/16. 03) Window A/C unit in medial reoffice unplugged from power strip plugged into appropriate outlet of 04) Extension cord in generator for removed on 6/21/16. 05) Wall conduit in ventilator/metroom in kitchen was repaired 6/2 06) Power strips in resident room removed on 6/28/16. All electrical deficiencies resolve maintenance department and comonitoring of electrical compliant completed by Maintenance Direct 	er was cord o and n 6/20/16. room was chanical 8/16. ns were d by ntinued ce will be	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted June 22, 2016

Ms. Patrice Goette, Administrator Trimont Health Care Center 303 Broadway Avenue South Trimont, Minnesota 56176

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5315025

Dear Ms. Goette:

The above facility was surveyed on June 6, 2016 through June 9, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

Trimont Health Care Center June 22, 2016 Page 2

statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Kathryn Serie, Unit Supervisor at (507) 476-4233.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s) cc: Original - Facility Licensing and Certification File

Minneso	ta Department of He	alth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00365	B. WING		06/0	9/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TRIMON	T HEALTH CARE CEN	ITER	ADWAY AVEN , MN 56176	NUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided that the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
ABORATOR	epartment of Health 7 DIRECTOR'S OR PROVIE ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 06/30/16

Electronically Signed

6899

If continuation sheet 1 of 27

STATEMEN	DIA Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00365	B. WING		06/09/201	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
TRIMON	T HEALTH CARE CE	NTER	ADWAY AVEN T, MN 56176	UE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	age 1	2 000			
	you electronically. is necessary for St enter the word "con text. You must ther State licensure pro completion date, th corrected prior to e Minnesota Departr On June 6-9, 2016 Department's staff the following correct Please indicate in y correction that you		, t			
	the State Licensing federal software. T	nent of Health is documenting correction Orders using ag numbers have been sota state statutes/rules for				
	column entitled "II statute/rule out of o "Summary Stateme and replaces the " correction order. T findings which are after the statement evidence by." Follo	number appears in the far left D Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute t, "This Rule is not met as wing the surveyors findings Method of Correction and rrection.				
	FOURTH COLUMI "PROVIDER'S PLA APPLIES TO FEDI	ARD THE HEADING OF THE N WHICH STATES, AN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. NR ON EACH PAGE.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY
		00365	B. WING		- 06/09/2016	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TRIMON	T HEALTH CARE CEN		ADWAY AVE T, MN 56176			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLET DATE
2 000	Continued From pa	ige 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 255	MN Rule 4658.007 Assurance Commit	0 Quality Assessment and tee	2 255			7/8/16
	assessment and as of the administrator services, the medic designated by the r three other membe representing discip resident care. The assurance committ respect to which qu necessary and dev appropriate plans o quality deficiencies address, at a minim	ust maintain a quality ssurance committee consisting r, the director of nursing cal director or other physician nedical director, and at least rs of the nursing home's staff, lines directly involved in quality assessment and ee must identify issues with iality assurance activities are elop and implement of action to correct identified . The committee must num, incident and accident control, and medications and				
	by: Based on interview facility failed to ens and assurance (QA required and mainta	ent is not met as evidenced and document review, the ure the quality assessment (A) committee met quarterly as ained required members. This affect all 21 residents residing	5	Corrected.		
	Findings include:					
	attendance logs fro	ty assurance meeting m 6/9/15 to 6/9/16, identified nmittee met once on 3/23/16				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00365	-		06/		
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	00/	06/09/2016		
	T HEALTH CARE CE	NTER 303 BRC	ADWAY AVEN T, MN 56176				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 255	Continued From pa	age 3	2 255				
	and no further evidence provided of meetings held during this time period.						
		or did not attend the quarterly meeting held 3/23/16.					
	director of nursing every 3 months but only one attendance in the meeting. The in her role and the meeting she had a there had been no were reviewed and identified information The DON indicated director. The DON different DON's an administrative role	n 6/9/16, at 3:30 p.m. the (DON) explained the QAA met t acknowledged there was ce record of staff participating e DON explained she was new 3/16 meeting was the first ttended. The DON verified action plans from 2015 that d/or continued in 2016. The on was not available for review d there was also a new medica indicated there were 3 d administrators in the during the past year. e policy/procedure was provided.	<i>.</i>				
	SUGGESTED ME The administrator of review, and/or revision ensure the quality a includes the require every quarter to en administrator or de appropriate staff of procedures. The additional procedures.	THOD OF CORRECTION: or designee could develop, se policies and procedures to assurance (QA) committee ed members and meets once usure ongoing compliance. The esignee could educate all n these policies and dministrator or designee could g systems to ensure ongoing					
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					E SURVEY PLETED	
		00365	B. WING		06/09/2016	
IAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE, ZIP CODE		
RIMON	T HEALTH CARE CEN	ITER	ADWAY AVEN F, MN 56176	UE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 540	Continued From pa	ge 4	2 540			
2 540	MN Rule 4658.0400 Resident Assessme	0 Subp. 1 & 2 Comprehensive ent	2 540			7/8/16
	resident's needs, w capability to perform significant impairment nursing assessment Minnesota Statutes 15, may be used as resident assessment comprehensive results used to develop, re- comprehensive plat 4658.0405. Subp. 2. Informat comprehensive resinclude at least the A. medically der medical history; B. medical stat C. physical and D. sensory and E. nutritional stat G. mental and H. discharge pu- I. dental condit J. activities pot K. rehabilitation L. cognitive stat M. drug therapy N. resident pre	ion; ential; n potential; tus; r; and				
	Based on interview facility failed to com	and document review, the prehensively assess and interventions for 2 of 2		Corrected.		

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
00365		00365	B. WING		06/09/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
	T HEALTH CARE CEN	NTER	ADWAY AVEN	UE SOUTH		
		IRIMON	Г, MN 56176			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 540	Continued From pa	ige 5	2 540			
		8) reviewed for incontinence s (R31) reviewed for				
	Findings include:					
	12/17/16, indicated impaired, and exper of bladder requiring hygiene. R31's qua indicated resident w indicated a decline indicated R31 was dangerous place. F look back dated 12	inimum Data Set (MDS) dated R31 was severely cognitively rienced frequent incontinence g assistance with personal rterly MDS dated 3/15/16 was always incontinent which in continence. The MDS also at risk for wandering to a Review of the 7 day behavior /11/15 indicated R31 had aced R31 at risk of danger on 6/15.				
	1/25/16 included b	oted on the care plan dated enign prostatic hypertrophy out behavioral symptoms.				
	12/17/15, indicated needed assistance indicated urinary in planned. However t lacked analysis of t include identifying t	area assessment (CAA) dated R31 had urinary urgency and in toileting. The CAA further continence would be care the CAA was incomplete and he urinary incontinence to he type of incontinence in developing appropriate				
	director of nurses (bladder assessmer them. The DON wo	on 6/9/16, at 12:28 p.m. the DON) was unable to locate a nt and indicated they do not do build not identify when she inary incontinence assessment				

STATEMEN	Dia Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
0036		00365	B. WING		06/	09/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	TATE, ZIP CODE		
TRIMON	T HEALTH CARE CEI	NTER	OADWAY AVEN NT, MN 56176	IUE SOUTH		
(X4) ID	SUMMARY STA		ID ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 540	Continued From pa	age 6	2 540			
	at immediate threa the past 7 days. The incomplete and lac assessment, analy regarding incontine indicated these issue During review of the dated 12/7/15, the indicated R31 was further indicated R32 communicate need present upon referent During an interview	<i>i</i> on 6/7/16, at 2:57 p.m. the	5			
	demonstrated any further indicated R3 wandering within th The SW reported F resident's room twi wheelchair. The SV was not placed initi but looking for his r indicated R31 did r	a indicated the resident had no wandering at the facility. SW 31 had 2 episodes of the first weeks of admission. R31 wandered into another ce but is now immobile in the N reported a wanderguard ially as he was not exit seeking room. The SW further not have an elopement risk eted upon admission.				
	the resident had be and was noted to w needed different pl redirect when wand indicated she was n assessment was co she would expect of adminstrator indica a wanderguard to b	a.m. the administrator reporte een in an assisted living facility vander while there. R31 acement due to limited staff to dering. The adminstrator not aware if a 24-48 hour ompleted and further indicated one to have been done. The tted she would have expected be placed and watch the ve the behavior especially if wanderer.				

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00365		00365	B. WING		06/	09/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
FRIMON	T HEALTH CARE CEN	NTFR	ADWAY AVEN T, MN 56176	UE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 540	Continued From pa	ge 7	2 540			
	(DON) indicated sh elopement assess could not provide a The Elopement pol 8/18/08, indicated c	e p.m. the director of nurses e was unaware of an nent being completed and ny further information. icy with a review date of during the admission process be assessed for the their risk				
	catheter. The care the rationale for the	with an indwelling Foley plan dated 4/13/16, identified use of the catheter was hronic pain, chemotherapy n breakdown.				
	assessment dated indwelling Foley ca Care Area Assessm status which could the Foley catheter. an assessment for ongoing use of a fo evidence of assess an indwelling cathe the catheter and co	inimum Data Set (MDS) 7/22/16, identified R28 with ar theter. The MDS lacked a nent (CAA) related to urinary address the continued use of R28's medical record lacked urinary status related to the ley catheter. There was no ment of the risks & benefits of ter; the potential for removal o insideration of complications use of the indwelling foley				
	(DON) confirmed F urinary assessmen for the ongoing use stated the closest r	o.m. the director of nursing 28's medical record lacked a t which included the rationale of the catheter. The DON eason she had for the use of was, "she (R28) has a chronic came with."				

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00365		00365	B. WING		06/09/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE	• • • •	
TRIMON	T HEALTH CARE CEI	NTER	ADWAY AVEI T, MN 56176	NUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 540	Continued From pa	age 8	2 540			
	director of nursing develop, review, ar procedures to ensu- are comprehensive to all appropriate si	THOD OF CORRECTION: The (DON) or designee could nd/or revise policies and ure resident MDS assessments e. Education could be provided taff and a monitoring system d to ensure ongoing				
	TIME PERIOD FO (21) Days	R CORRECTION: Twenty-one				
2 560	MN Rule 4658.040 Plan of Care; Cont	5 Subp. 2 Comprehensive ents	2 560			7/15/16
	comprehensive pla objectives and time long- and short-tern and mental and ps identified in the cor assessment. The must include the in	of plan of care. The in of care must list measurable etables to meet the resident's m goals for medical, nursing, ychosocial needs that are nprehensive resident comprehensive plan of care dividual abuse prevention plan sota Statutes, section 626.557, agraph (b).				
	by: Based on observat review the facility fa comprehensive car	ent is not met as evidenced ion, interview and document ailed to develop a re plan related to dental care sidents reviewed for dental		Corrected		
	Findings include:					
	6:39 p.m. resident	is of dementia. On 6/6/16, at was noted to be missing all of d had only two visible teeth on				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED	
0036		00365	B. WING			06/09/2016	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE			
RIMON	T HEALTH CARE CE	NTER	ADWAY AVEN T, MN 56176	UE SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE	
2 560	Continued From pa	age 9	2 560				
	her lower gum line dentures/partials ir	s. She did not have any the mouth.					
	3/7/16, identified R Interview for Menta severe cognitive in extensive assistant personal hygiene. I as having obvious natural teeth. The 0 dated 3/7/16, ident addressed in the c Review of R18's ca of 6/8/16, did not in deficit problems, guthe management of During interview or assistant (NA)-B st	are plan with last revision date include any ADL or self care oals, or interventions related to of dental care. n 6/9/16, at 10:15 a.m. nursing tated R18 had an upper					
		d to wear it. NA-B further assistance to complete her ach day.					
	director of nursing did not include a de have. However, th assistants use the	n 6/9/16, at 11:07 a.m. the (DON) confirmed the careplan ental/oral care plan, but should e DON stated the nursing care plan on the kiosk for problems, goals, and visible there.					
		n 6/9/16, at 11:26 a.m. NA-E I/dental plan of care existed on					
	Procedures for Ca	Health Care Center Policy and re Plan Conference & Care revised 6/9/10, directed staff to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00365		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY IPLETED
		00365	B. WING		06/09/2016	
	PROVIDER OR SUPPLIER	303 BRG	DDRESS, CITY, S DADWAY AVEN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE
2 560	develop an individu plan that would incl SUGGESTED MET The director of nurs develop and impler related to the care could provide traini to the development assessment. The E develop monitoring compliance. TIME PERIOD FOI (21) days. MN Rule 4658.052 Proper Nursing Car Subpart 1. Care in	alized comprehensive care ude dental condition. THOD OF CORRECTION: sing (DON) or designee, could nent policies and procedures plan. The DON or designee, ng for all nursing staff related of the care plan based on the DON or designee could systems to ensure ongoing R CORRECTION: Twenty-one	2 830			7/8/16
	custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t resident must rema prefers to remain in This MN Requirem by: Based on observat review the facility fa	supervision based on id preferences as identified in resident assessment and scribed in parts 4658.0400 an ing home resident must be ou possible unless there is a he attending physician that the in in bed or the resident	d t	Corrected.		

	Dia Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
00		00365	B. WING		06/09/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
TRIMON	T HEALTH CARE CE	NTFR	ADWAY AVEN T, MN 56176	UE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 11	2 830			
	residents (R5) revi	ewed for hospice.				
	Findings include:					
	assessment dated cognitively intact, with activities of da	ange Minimum Data Set (MDS) 2/23/16, identified R5 as required extensive assistance ally living (ADL), and had a han 6 months to live.				
	that R5 received he	revised on 5/31/16, identified ospice services and that rould be available for the				
	R5 received skilled weekly and as nee three times per mo five times per week times per month an	of care dated 5/26/16, indicated I nursing visits one to two times ded, social worker visits one to onth and as needed, aide visits k, chaplain visits one to three nd as needed, and volunteer mes per month and as needed.	5			
	nursing assistant (aware R5 received hospice aide came time. NA-D was un	n on 6/8/16, at 7:49 a.m. NA)-D indicated she was I hospice services because a e everyday to assist her at lunch ware whether any other spice visited or when the visits				
		n on 6/8/16, at 12:36 p.m. a noted to be assisting R5 to eat				
	social service designation aware the hospice the prior day and the the prior day and	on 6/8/16, at 1:05 p.m. the gnee (SSD) indicated she was nurse had been to the facility nat a hospice aide came riday to assist R5 with her				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00365	B. WING		06/09/2016	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
RIMON	T HEALTH CARE CE	NTER	ADWAY AVEN T, MN 56176	IUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 830	Continued From pa	age 12	2 830			
	gave a verbal repo updates and docur However, she was schedule nor when During interview or practical nurse (LP came everyday at l unaware of the hos whether there was skilled nursing visit On 6/8/16, at 1:07 (DON) indicated sh skilled nursing visit did not know if ther communicated and On 6/9/16, at 1:31 (RN) case manage weekly and "shoots and then named M Wednesday. She "target day". The h provide a schedule facility staff when s	p.m. the director of nursing ne was unaware of the hospice s for R5. The DON stated she				
		ted to coordination of care with sted, but none was provided.	ו			
	director of nursing review and revise p coordination of hos designee could edu outside vendors or	THOD OF CORRECTION: The (DON) or designee could policies related to the spice services. The DON or ucate all appropriate staff and those policies. The DON or onitor to ensure ongoing	•			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3) DATE SURVEY COMPLETED
00365		B. WING		06/09/2016	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
RIMON	T HEALTH CARE CEN		ADWAY AVE , MN 56176	NUE SOUTH	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLET
2 830	Continued From pa	ge 13	2 830		
	compliance, and re assurance committ	view results with the quality ee.			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one			
2 910	MN Rule 4658.052 Incontinence	5 Subp. 5 A.B Rehab -	2 910		7/8/16
	have a continuous management to rec unnecessary use o comprehensive res home must ensure A. a resident w without an indwellir unless the resident that catheterization B. a resident w receives appropriat prevent urinary trac	nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the ident assessment, a nursing that: ho enters a nursing home og catheter is not catheterized 's clinical condition indicates was necessary; and ho is incontinent of bladder the treatment and services to at infections and to restore as her function as possible.			
	by: Based on interview facility failed to com identify appropriate	ent is not met as evidenced and document review, the prehensively assess and interventions for 2 of 2 8) reviewed for incontinence.		Corrected.	
	Findings include:				
	12/17/16, indicated	finimum Data Set (MDS) dated R31 was severely cognitively rienced frequent incontinence			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00365	B. WING		06/	00/00/0010	
					06/09/2016		
	PROVIDER OR SUPPLIER		DDRESS, CITY, S ⁻ DADWAY AVEN				
RIMON	T HEALTH CARE CEI	NTER	T, MN 56176	02 000 111			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 910	Continued From pa	age 14	2 910				
	indicated a decline was always inconti on the care plan da prostatic hypertrop behavioral sympton assessment (CAA) had urinary urgenc toileting. The CAA incontinence would CAA was incomple urinary incontinence	arterly MDS dated 3/15/16, in incontinence as resident nent. R31's diagnoses noted ated 1/25/16 included benign hy and dementia without ms. Review of the care area dated 12/17/15 indicated R31 y and needed assistance in further indicated urinary d be care planned. However the te and lacked analysis of the se to include identifying the type order to assist with developing intions.	e				
	director of nurses (bladder assessment them. The DON wo	v on 6/9/16, at 12:28 p.m. the (DON) was unable to locate a nt and indicated they do not do buld not identify when she rinary incontinence assessmen					
	A bladder incontine not provided.	ence policy was requested but					
	catheter. The care the rationale for the	with an indwelling Foley plan dated 4/13/16, identified use of the catheter was chronic pain, chemotherapy in breakdown.					
	assessment dated indwelling Foley ca Care Area Assessr status which could the Foley catheter. an assessment for	linimum Data Set (MDS) 7/22/16, identified R28 with ar theter. The MDS lacked a nent (CAA) related to urinary address the continued use of R28's medical record lacked urinary status related to the oley catheter. There was no	1				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00365	B. WING		06/	06/09/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE			
	T HEALTH CARE CEN	NTER	OADWAY AVEN NT, MN 56176	UE SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 910	Continued From pa	age 15	2 910				
	indwelling catheter the catheter and co	of the risks & benefits of an the potential for removal of posideration of complications use of the indwelling foley					
	R28's foley cathete on the 24th and as	ers signed 5/31/16, identified or should be changed monthly needed. The physician order rationale for the use of the					
	(DON) confirmed F urinary assessmen for the ongoing use stated the closest r	p.m. the director of nursing R28's medical record lacked a t which included the rationale of the catheter. The DON reason she had for the use of was, "she (R28) has a chron came with."					
	The director of nurs all residents at risk they are receiving t treatment/services incontinence. The l educate all appropri provision of service	to prevent/minimize DON or designee, could riate staff on the appropriate es for incontinence. The DON conduct random audits to					
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-on	e				
21015	MN Rule 4658.061 Requirements- Sa	0 Subp. 7 Dietary Staff nitary conditi	21015			7/8/16	
		conditions. Sanitary nditions must be maintained i	in				

	T OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED	
		00365	B. WING	B WING		06/09/2016	
	ROVIDER OR SUPPLIER			STATE, ZIP CODE	00/	09/2010	
	HEALTH CARE CE	NTER 303 BRC	ADWAY AVE	NUE SOUTH			
		TRIMON	T, MN 56176				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21015	Continued From pa	age 16	21015				
	the operation of the times.	e dietary department at all					
	by:	nent is not met as evidenced					
	review the facility fautensils were clear	tion, interview and document ailed to assure dishes and ned under sanitary conditions. tial to affect all 23 residents lity.		Corrected.			
	Findings include:						
	was observed to pudishwasher. The was registered 100 deg again processed a the dish machine.	a.m. the dietary manager (DM) rocess dirty dishes through the vash water temperature grees Fahrenheit. The DM nother load of dishes through The wash temperature again gistered at 100 degrees					
	dishes was washed dishwasher and the time registered 100 6/8/16, at 12:25 p. 118 degrees. On 6 temperature did no than 100 degrees i dishes were obsert dishwasher. With pushed the fill butte load. The temperation	D a.m. another load of soiled d via the automated e water temperature at this D degrees Fahrenheit. On .m. the wash temperature was 6/9/16, at 8:48 a.m. the wash of register a temperature higher Fahrenheit. Two loads of ved to be run through the each of these loads, staff on several times with each ture still did not go above 100 it. These temperatures were aide (DA)-A.	r				
		perature logs for 4/16, 5/16. I that temperatures for the					

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00365	B. WING	B. WING		06/09/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE, ZIP CODE				
TRIMON	T HEALTH CARE CEI	NTER	OADWAY AVEN NT, MN 56176	UE SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21015		-	21015				
	degrees Fahrenhei months. The wash	cle was at or above 120 it 12 times during the past 3 in temperatures for the lunch neasured at or above 120 mes.					
	identified the dishw sanitation unit. She be over 120 degree temperatures were usually warmed up She stated they we the machine but sta doesn't change the had brought this is director in 3/16 or 4 with the chemical s	n 6/9/16, at 8:22 a.m. the DM vasher was a chemical e stated the wash cycle should es. The DM stated the mornin always low and indicated it around 9:30 or 10:00 a.m ere told to hit the fill button on aff have been doing this and i e temperature. She stated she sue to the maintenance 4/16. The DM confirmed that canitation the wash cycle 0 degrees Fahrenheit.	g t				
	6/9/16, at 8:55 a.m fill several times. W	th the maintenance director o . he stated they have to hit the Vhen informed this did not wo re remained low, he stated, "I o look into it."	e				
	provided by the fac operating temperat	n machine product detail shee ility identified that the ture for the machine should be degrees Fahrenheit for the					
	dietary manager (D procedures regardi temperatures base recommendations include a system for equipment in a time	THOD OF CORRECTION: Th DM) could develop policies and ing safe dishwasher operating of off the manufacturer's and guidelines. This could or notification and repair of ely manner. The DM could riate staff on these policies.	d				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/09/2016	
		00365	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE		
RIMON	T HEALTH CARE CEI	NTER	OADWAY AVE NT, MN 56176			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
21015	Continued From pa	age 18	21015			
	The DM could deve ensure ongoing co	elop monitoring systems to mpliance.				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one	e			
21375	MN Rule 4658.080 Program	0 Subp. 1 Infection Control;	21375			7/8/16
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.	3			
	by: Based on interview facility failed to ens prevention and con symptom screening and residents and skin test (TST) for assistant (NA)-F, N	ent is not met as evidenced and document review, the sure a Tuberculosis (TB) atrol program included a TB g of all newly hired employees included a two step tuberculin 5 of 5 employees (nursing IA-G, NA-H, maintenance er (H)-A) and 5 of 5 residents 35, R37).		Corrected.		
	Findings Include:					
	first administration (TST) on 5/23/16.	date was 5/23/16, received the of the tuberculin skin test The symptom screen and not completed or administered				
	administration of th	te of 5/2/16, received the first le TST on 5/2/16. The nd second TST were not nistered.				

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		00365	B. WING		06/09/20		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	ADDRESS, CITY, STATE, ZIP CODE				
TRIMON	T HEALTH CARE CEN	ITFR	ADWAY AVEN , MN 56176	UE SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21375	NA-F, with a hire da	ate of 1/4/16, received the first	21375				
		e TST on 1/4/16. The nd second TST were not nistered.					
	first administration	date was 5/13/16, received the of the TST on 5/13/16. The nd second TST were not nistered.					
	the first administrat	late was 12/21/15, received ion of the TST on 12/21/15. en and second TST were not histered.					
	administration of th	e of 3/15/16, received the first e TST on 4/1/16. The nd second TST were not nistered.					
	administration of th	e of 3/22/16, received the first e TST on 4/8/16. The nd second TST were not nistered.					
	second administrat	e 2/9/16, received the first and ion of the TST on 2/10/16 and iom screen was not					
	and second admini	e 12/7/15, received the first stration of the TST on 12/8/15 symptom screen was not					
	second administrat	e 4/7/16, received the first and ion of the TST on 4/8/16 and om screen was not					

DGKY11

If continuation sheet 20 of 27

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00365	B. WING	B. WING		09/2016
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
RIMON	T HEALTH CARE CE	NIER	ADWAY AVEN T, MN 56176	UE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	age 20	21375			
	administrator verifination of completed according	v on 6/7/16, at 11:00 a.m. the ed the 2 step TB testing was ording to the TB regulations for loyees newly hired/admitted.	r			
	Step for Employee indicated the first c (Mantoux) would b	cedure Mantoux Testing Two s, review date 5/14/10, of the two step TB test e done prior to the employees cond Mantoux would be				
	review date 5/7/07 required to have a admission and a se	cedure Mantoux-Resident, , indicated all residents were two-step Mantoux on econd TST should be 4 days after the first.				
	director of nursing review and revise p to the components monitoring program educated on the TI Mantoux process.	THOD OF CORRECTION: The (DON) and/or designee could policies and procedures related of the infection control and TE n. Facility staff could be B regulations and the two step The director of nursing and/or velop a monitoring system to mpliance.	ł }			
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty one	-			
21830	MN St. Statute 144 Residents of HC F	I.651 Subd. 10 Patients & ac.Bill of Rights	21830			7/8/16
	Subd. 10. Partici notification of famil	pation in planning treatment; y members.				
		Il have the right to participate heir health care. This right				

STATE FORM

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING: _	BUILDING.			
		00365	B. WING		06/09/2016		
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
TRIMON	T HEALTH CARE CE	NIFR	ADWAY AVEN T, MN 56176	UE SOUTH			
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE	
21830	Continued From pa	age 21	21830				
	alternatives with in- opportunity to requi- care conferences, family member or of both. In the event present, a family m- chosen by the resid conferences. (b) If a resident with unconscious or con- communicate, the efforts as required either a family mem- writing by the resid an emergency that admitted to the fac- family member to p- planning, unless th to believe the resid directive to the com- specified in writing member included i notifying a family m- family member to p- planning, the facilit efforts, consistent w- practice, to determ executed an advar esident's health ca- this paragraph, "re- (1) examining th- resident; (2) examining th- resident in the pos- (3) inquiring of a family member cor- whether the reside	tunity to discuss treatment and dividual caregivers, the est and participate in formal and the right to include a other chosen representative or that the resident cannot be nember or other representative dent may be included in such who enters a facility is matose or is unable to facility shall make reasonable under paragraph (c) to notify nber or a person designated in ent as the person to contact in the resident has been ility. The facility shall allow the participate in treatment e facility knows or has reason lent has an effective advance trary or knows the resident has that they do not want a family n treatment planning. After nember but prior to allowing a participate in treatment y must make reasonable with reasonable medical ine if the resident has nee directive relative to the re decisions. For purposes of asonable efforts" include: e personal effects of the session of the facility; ny emergency contact or ttacted under this section nt has executed an advance her the resident has a					

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00365	B. WING		06/09/2016	
NAME OF	PROVIDER OR SUPPLIER	L	ADDRESS, CITY, S	TATE. ZIP CODE		00/2010
		303 BD	OADWAY AVEN			
	T HEALTH CARE CEN	TRIMOI	NT, MN 56176			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21830	Continued From pa	ge 22	21830			
	care; and (4) inquiring of the resident normally g whether the resider directive. If a facilit designated emerge member to participa accordance with thi liable to resident for the notification of the emergency contact family member was patient's privacy rig (c) In making real family member or of the facility shall atter members or a desig examining the pers and the medical rec possession of the facil social service agen agency that the res the facility has been member or designated emerge county social service enforcement agence identifying and notif designated emerge service agency or lo that assists a facilit subdivision is not lia damages on the gra	asonable efforts to notify a designated emergency contact empt to identify family gnated emergency contact by onal effects of the resident cords of the resident in the acility. If the facility is unable ember or designated within 24 hours after the ity shall notify the county cy or local law enforcement ident has been admitted and n unable to notify a family ated emergency contact. The ce agency and local law cy shall assist the facility in ying a family member or ancy contact. A county social local law enforcement agency y in implementing this able to the resident for bunds that the notification of or emergency contact or the family member was improper	/ t at			

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00365	B. WING		06/	06/09/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		50,00,2010	
	THEALTH CARE CEN	NIFR	ADWAY AVE F, MN 56176	NUE SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE	
21830	Continued From pa	age 23	21830				
	by: Based on interview facility failed to acc	ent is not met as evidenced and document review the commodate bathing choices for 35, R28) reviewed for choices.		Corrected.			
	not offered a choice (frequency) she red stated, "everyone g they told me when if she thought she c or shower per week	(16, at 3:31 p.m. that she was e in how many times a week ceived a bath/shower. She gets one a week, that's what I came in here." When asked could have more than one bath k she stated, "Nope you can't. e gets one a week and that's					
	p.m. R35 stated "th you can only have p.m. R35 stated sh than one bath as sl one. She stated, "l	ent interview on 6/7/16, at 1:56 ney tell you when you come in one bath". On 6/9/16, at 11:49 le had never asked for more he was told you can only have I would like more than one t it is getting hot out."					
	(MDS) assessment had a Brief Intervie score of 15/15, indi of the admission nu 3/15/16, identified t a.m. (morning) bat	ission Minimum Data Set t dated 3/22/16, identified R35 w for Mental Status (BIMS) icating intact cognition. Review ursing assessment dated that R35 preferred to take an h. It did not identify whether than one bath a week.					
maasta D		16, at 6:01 p.m., that everyone eek, that's what they told me".					

	NT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00365	B. WING		06/	6/09/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
FRIMON	T HEALTH CARE CE	NTER	DADWAY AVEN T, MN 56176	UE SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21830		age 24 9 a.m., R28 again stated that	21830				
	do one bath a wee never requested ar she could only hav	hitted facility staff told her, "we k here". She indicated she hav nother bath as she was told e one. She stated it would be an one bath a week.					
	BIMS score of 15/1 Review of the adm	2/29/16, identified R28 with a 15, indicating intact cognition. ission nursing assessment did preference for bathing					
	assistant (NA)-A st	n 6/9/16, at 12:35 p.m. nursing ated that when residents were given one bath a week.					
	worker (SW) stated	n 6/8/16, at 8:02 a.m. the socia d she did not address bathing mission as that was part of the process.					
	practical nurse (LP specifically asked r	n 6/8/16, at 8:15 a.m. licensed N)-A stated she had never newly admitted residents ed more than one bath a week ed at resident care					
	staff was supposed preferred a mornin one bath a week is She stated this sho	S p.m. the administrator stated d to ask residents whether they g or evening bath and whether ok or would they like more. build be asked of all residents they had a choice.	/				
		/08, identified the facility's staf paths/showers "on their ay."	f				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		SURVEY PLETED
			A. BOILDING.			
		00365	B. WING		06/0	09/2016
IAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
RIMON	T HEALTH CARE CEI	NTER	ADWAY AVEN T, MN 56176	IUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLE DATE
21830	Continued From pa	age 25	21830			
	The director of nur- development and in procedures to ensu- choices in their dai designee could edu the policies and pro-	THOD OF CORRECTION: sing (DON) or designee could mplement policies and ure all residents are offered ly routines. The DON or ucate all appropriate staff on ocedures. The DON or nitor to ensure ongoing				
	TIME PERIOD FO (21) days	R CORRECTION: Twenty one)			
21915	MN St. Statute 144 Residents of HC F	.651 Subd. 27 Patients & ac.Bill of Rights	21915			6/28/16
	their families shall maintain, and partii family councils. Ea assistance and spa meetings shall be a visitors attending o invitation. A staff p responsibility of pro responding to writte council meetings.	ry councils. Residents and have the right to organize, cipate in resident advisory and ach facility shall provide ace for meetings. Council afforded privacy, with staff or nly upon the council's erson shall be designated the oviding this assistance and en requests which result from Resident and family councils ed to make recommendations olicies.				
	by: Based on interview facility failed to atte council on at least	ent is not met as evidenced and document review the empt to organize a family an annual basis. This had the Il 23 resident families who A		Corrected.		
	Findings include:					

STATE FORM

DGKY11

If continuation sheet 26 of 27

Minnesota Department of He STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED
		00365			06/09/2016
RIMONT HE	ALTH CARE CEI	NIFR	ADWAY AVEN T, MN 56176	UE SOUTH	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLET THE APPROPRIATE DATE
21915 Cor	ntinued From pa	age 26	21915		
serrinot furt to c stat A fa but SUU adm atte moi are TIM	vice designee (S have an existin her confirmed s organize a family ting she was un acility policy on f none was provi GGESTED MET ninistrator or de empts are made e administrator or nitoring systems made to initiate	n 6/6/16, at 2:30 p.m. social SSD) confirmed the facility did g family council. The SSD the had not formally attempted y council in the past year aware of this requirement. THOD OF CORRECTION: The signee could ensure thorough to develop a family council. or designee could develop is to ensure thorough attempts the family council. R CORRECTION: Twenty-one	•		