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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DGKY

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00365

1. MEDICARE/MEDICAID PROVIDER NO.(L 1) **245315**

2. STATE VENDOR OR MEDICAID NO. (L 2) **541743100**

3. NAME AND ADDRESS OF FACILITY
(L3) **TRIMONT HEALTH CARE CENTER**
(L4) **303 BROADWAY AVENUE SOUTH**
(L5) **TRIMONT, MN** (L6) **56176**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **8/2/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **36** (L18)

13.Total Certified Beds **36** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

B.IIINotIinICmplianceIwithIProgram Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	36			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Joseph Garvey, HFE NE II 8/11/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 8/11/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **06/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

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,

Kamala Fiske-Downing

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

MDH
Minnesota Department of Health

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, effective July 15, 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,

Kamala Fiske-Downing

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245315 Y1	A. Building B. Wing Y2	8/2/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0242	Correction	ID Prefix F0272	Correction	ID Prefix F0278	Correction
Reg. # 483.15(b)	Completed	Reg. # 483.20(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	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	KS/kfd	8/11/2016	22113	8/2/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
6/9/2016

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245315 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	7/24/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	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	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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101, 483.70(a)(7)	Completed
LSC K0050	06/29/2016	LSC K0051	07/15/2016	LSC K0053	07/15/2016
ID Prefix	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	07/15/2016	LSC K0062	06/22/2016
ID Prefix	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

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	8/11/2016	35482	7/24/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245315 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	7/24/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	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).

ITEM Y4	ID Prefix	Reg. #	LSC	DATE Y5	Correction Completed
		NFPA 101	K0074	07/15/2016	
		NFPA 101	K0076	06/23/2016	
		NFPA 101	K0144	06/30/2016	
		NFPA 101	K0147	06/29/2016	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☐	TL/kfd	8/11/2016	35482	7/24/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
6/8/2016

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

MDH
Minnesota
Department
of Health

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,

Kamala Fiske-Downing

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

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00365 Y1	A. Building B. Wing Y2	8/2/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20255	Correction	ID Prefix 20540	Correction	ID Prefix 20560	Correction
Reg. # MN Rule 4658.0070	Completed	Reg. # MN Rule 4658.0400 Subp. 1 & 2	Completed	Reg. # MN Rule 4658.0405 Subp. 2	Completed
LSC	07/08/2016	LSC	07/08/2016	LSC	07/08/2016
ID Prefix 20830	Correction	ID Prefix 20910	Correction	ID Prefix 21015	Correction
Reg. # MN Rule 4658.0520 Subp. 1	Completed	Reg. # MN Rule 4658.0525 Subp. 5 A.B	Completed	Reg. # MN Rule 4658.0610 Subp. 7	Completed
LSC	07/08/2016	LSC	07/08/2016	LSC	07/08/2016
ID Prefix 21375	Correction	ID Prefix 21830	Correction	ID Prefix 21915	Correction
Reg. # MN Rule 4658.0800 Subp. 1	Completed	Reg. # MN St. Statute 144.651 Subd. 10	Completed	Reg. # MN St. Statute 144.651 Subd. 27	Completed
LSC	07/08/2016	LSC	07/08/2016	LSC	07/08/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) KS/kfd	DATE 8/11/2016	SIGNATURE OF SURVEYOR 22113	DATE 8/2/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
6/9/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DGKY

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00365

1. MEDICARE/MEDICAID PROVIDER NO.(L 1) **245315**

2. STATE VENDOR OR MEDICAID NO. (L 2) **541743100**

3. NAME AND ADDRESS OF FACILITY
(L3) **TRIMONT HEALTH CARE CENTER**
(L4) **303 BROADWAY AVENUE SOUTH**
(L5) **TRIMONT, MN** (L6) **56176**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **06/09/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **36** (L18)

13.Total Certified Beds **36** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	36			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Pamela Manzke, HFE NE II 07/11/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 07/27/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **06/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
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:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**

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

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

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

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

DEPARTMENT CONTACT

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

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to accommodate bathing choices for 2 of 3 residents (R35, R28) reviewed for choices. Findings include: R35 stated on 6/6/16, at 3:31 p.m. that she was not offered a choice in how many times a week (frequency) she received a bath/shower. She stated, "everyone gets one a week, that's what	F 242	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	7/8/16

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

Electronically Signed | 06/30/2016

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F 242	Continued From page 1 they told me when I came in here." When asked if she thought she could have more than one bath or shower per week she stated, "Nope you can't. They said everyone gets one a week and that's it." During an subsequent interview on 6/7/16, at 1:56 p.m. R35 stated "they tell you when you come in you can only have one bath". On 6/9/16, at 11:49 p.m. R35 stated she had never asked for more than one bath as she was told you can only have one. She stated, "I would like more than one especially now that it is getting hot out." Review of the admission Minimum Data Set (MDS) assessment dated 3/22/16, identified R35 had a Brief Interview for Mental Status (BIMS) score of 15/15, indicating intact cognition. Review of the admission nursing assessment dated 3/15/16, identified that R35 preferred to take an a.m. (morning) bath. It did not identify whether R35 desired more than one bath a week. R28 stated on 6/6/16, at 6:01 p.m., that everyone gets "one bath a week, that's what they told me". On 6/9/16, at 11:49 a.m., R28 again stated that when she was admitted facility staff told her, "we do one bath a week here". She indicated she had never requested another bath as she was told she could only have one. She stated it would be nice to get more than one bath a week. The MDS dated 12/29/16, identified R28 with a BIMS score of 15/15, indicating intact cognition. Review of the admission nursing assessment did not identify R28's preference for bathing frequency. During interview on 6/9/16, at 12:35 p.m. nursing	F 242	each resident and changes made and care planned to meet their choices. To ensure that this doesn't recur the "Bath Preference Inquiry" will be completed at admission, quarterly and with significant changes. At each resident care conference bath preference will be reviewed. Education to be done with staff regarding use of Bath Preference Inquiry, revised policy and procedure regarding bathing and a refresher on the resident's right to make choices regarding their daily routine. To monitor for compliance, the DON will randomly audit the bath preference process.	

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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 242		
F 272 SS=D	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 272		7/8/16

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F 272	Continued From page 3 Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess and identify appropriate interventions for 2 of 2 residents (R31, R28) reviewed for incontinence and 1 of 1 residents (R31) reviewed for wandering. Findings include:	F 272	Corrective action for R31 related to urinary incontinence - a bladder assessment to be completed and addressed on the care plan with appropriate interventions. Corrective action for R31 related to wandering - an elopement/wandering assessment to be completed and	

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F 272	Continued From page 4 R31's admission Minimum Data Set (MDS) dated 12/17/16, indicated R31 was severely cognitively impaired, and experienced frequent incontinence of bladder requiring assistance with personal hygiene. R31's quarterly MDS dated 3/15/16 indicated resident was always incontinent which indicated a decline in continence. The MDS also indicated R31 was at risk for wandering to a dangerous place. Review of the 7 day behavior look back dated 12/11/15 indicated R31 had wandered which placed R31 at risk of danger on 12/15/15 and 12/16/15. R31's diagnoses noted on the care plan dated 1/25/16 included benign prostatic hypertrophy and dementia without behavioral symptoms. Review of the care area assessment (CAA) dated 12/17/15, indicated R31 had urinary urgency and needed assistance in toileting. The CAA further indicated urinary incontinence would be care planned. However the CAA was incomplete and lacked analysis of the urinary incontinence to include identifying the type of incontinence in order to assist with developing appropriate interventions. During an interview on 6/9/16, at 12:28 p.m. the director of nurses (DON) was unable to locate a bladder assessment and indicated they do not do them. The DON would not identify when she would expect an urinary incontinence assessment to be done. The CAA dated 12/17/15, also indicated R31 was at immediate threat to self and had wandered in the past 7 days. The CAA worksheet was incomplete and lacked comprehensive assessment, analysis or interventions developed	F 272	addressed on the care plan with appropriate interventions. Corrective action for R28 related to catheter - a bladder assessment to be completed and care planned with appropriate interventions regarding risks and benefits; also request documentation from physician stating diagnosis and rationale for catheter. The facility will identify other residents potentially being affected by completing a bladder assessment and an elopement/wandering assessment at admission, quarterly and with significant changes. To ensure this practice doesn't recur random audits will be done by the DON and reviewed at quarterly QA & A meetings. Education to be provided regarding bladder and elopement/wandering assessments and policies and procedures related to the assessments.	

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F 272	Continued From page 5	F 272		

regarding incontinence or wandering and indicated these issues would be care planned.

During review of the admission progress notes dated 12/7/15, the social worker (SW) notes indicated R31 was a known wanderer. The notes further indicated R31 was alert, oriented, able to communicate needs with no behavior indicators present upon referral.

During an interview on 6/7/16, at 2:57 p.m. the social worker (SW) indicated the resident had not demonstrated any wandering at the facility. SW further indicated R31 had 2 episodes of wandering within the first weeks of admission. The SW reported R31 wandered into another resident's room twice but is now immobile in the wheelchair. The SW reported a wanderguard was not placed initially as he was not exit seeking but looking for his room. The SW further indicated R31 did not have an elopement risk assessment completed upon admission.

On 6/8/16, at 8:20 a.m. the administrator reported the resident had been in an assisted living facility and was noted to wander while there. R31 needed different placement due to limited staff to redirect when wandering. The adminstrator indicated she was not aware if a 24-48 hour assessment was completed and further indicated she would expect one to have been done. The adminstrator indicated she would have expected a wanderguard to be placed and watch the resident and observe the behavior especially if they were a known wanderer.

On 6/9/16 at 12:28 p.m. the director of nurses (DON) indicated she was unaware of an elopement assessment being completed and

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F 272	Continued From page 6 could not provide any further information. The Elopement policy with a review date of 8/18/08, indicated during the admission process all residents would be assessed for the their risk of elopement. R28 was admitted with an indwelling Foley catheter. The care plan dated 4/13/16, identified the rationale for the use of the catheter was impaired mobility, chronic pain, chemotherapy use and risk for skin breakdown. R28's admission Minimum Data Set (MDS) assessment dated 7/22/16, identified R28 with an indwelling Foley catheter. The MDS lacked a Care Area Assessment (CAA) related to urinary status which could address the continued use of the Foley catheter. R28's medical record lacked an assessment for urinary status related to the ongoing use of a foley catheter. There was no evidence of assessment of the risks & benefits of an indwelling catheter; the potential for removal of the catheter and consideration of complications resulting from the use of the indwelling foley catheter. On 6/9/16, at 2:09 p.m. the director of nursing (DON) confirmed R28's medical record lacked a urinary assessment which included the rationale for the ongoing use of the catheter. The DON stated the closest reason she had for the use of the Foley catheter was, "she (R28) has a chronic foley catheter she came with."	F 272		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the	F 278		7/5/16

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F 278	Continued From page 7 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. Findings include: During observation on 6/6/16, at 3:06 p.m. R13 was observed to have carious teeth on the top	F 278	Corrective action - education provided on appropriate coding of MDS for staff completing Section L Oral/Dental Status. To identify residents that may be affected and to ensure future compliance so this deficient practice doesn't recur the DON will randomly check that the dental assessments are being completed and	

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F 278	Continued From page 8 front of her mouth. A dental note dated 2/16/15, identified that tooth #9 had been fractured off at the gumline. The annual dental assessment conducted 11/5/15, identified R13 refused to open mouth and became combative when staff attempted to observe mouth and teeth. Review of the annual Minimum Data Set (MDS) dated 11/10/15, did not identify the dental exam was unable to be completed by staff. The following was documented "none of the above were present"- which referenced the following items: (a.) broken or loosely fitting full or partial denture; (b.) no natural teeth or tooth fragments; (c.) abnormal mouth tissue; (d.) obvious or likely cavity or broken natural teeth; (e.) inflamed or bleeding gums or loose natural teeth; and (f.) mouth or facial pain, discomfort or difficulty with chewing. During interview on 6/9/16, at 1:30 p.m. the director of nurses (DON) verified the MDS was inaccurate and should have been coded as "unable to complete exam".	F 278	coded accurately on the MDS prior to signing and certifying the accuracy of the MDS.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are	F 279		7/8/16

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F 279	Continued From page 9 to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to develop a comprehensive care plan related to dental care for 1 of 3 (R18) residents reviewed for dental services. Findings include: R18 had a diagnosis of dementia. On 6/6/16, at 6:39 p.m. resident was noted to be missing all of her teeth on top and had only two visible teeth on her lower gum lines. She did not have any dentures/partials in the mouth. The admission Minimum Data Set (MDS) dated 3/7/16, identified R18 as having a BIMS (Brief Interview for Mental Status) score of 4 indicating severe cognitive impairment and needing extensive assistance of one staff member with personal hygiene. Furthermore, it identified R18 as having obvious or likely cavity or broken natural teeth. The Care Area Assessment (CAA) dated 3/7/16, identified that dental care would be addressed in the care plan. Review of R18's care plan with last revision date of 6/8/16, did not include any ADL or self care	F 279	Corrective action for R18 - develop a comprehensive care plan related to dental care based on dental assessment. To identify other residents that may potentially be affected, care plans to be reviewed and revised as needed to reflect accurate ADL or self care deficit problems, goals or interventions. Education to be provided regarding development of a comprehensive care plan. To ensure deficient practice doesn't recur care plans will be randomly audited by DON or MDS LPN.	

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F 279	Continued From page 10 deficit problems, goals, or interventions related to the management of dental care. During interview on 6/9/16, at 10:15 a.m. nursing assistant (NA)-B stated R18 had an upper denture but refused to wear it. NA-B further stated R18 needed assistance to complete her oral/dental cares each day. During interview on 6/9/16, at 11:07 a.m. the director of nursing (DON) confirmed the careplan did not include a dental/oral care plan, but should have. However, the DON stated the nursing assistants use the care plan on the kiosk for cares. Dental care problems, goals, and interventions were visible there. During interview on 6/9/16, at 11:26 a.m. NA-E verified that no oral/dental plan of care existed on the kiosk for R18. Review of Trimont Health Care Center Policy and Procedures for Care Plan Conference & Care plan requirements revised 6/9/10, directed staff to develop an individualized comprehensive care plan that would include dental condition.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		7/8/16

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	245315	A. BUILDING _____ B. WING _____	06/09/2016

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F 309	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure services were coordinated with the hospice agency for 1 of 1 residents (R5) reviewed for hospice. Findings include: R5's significant change Minimum Data Set (MDS) assessment dated 2/23/16, identified R5 as cognitively intact, required extensive assistance with activities of daily living (ADL), and had a prognosis of less than 6 months to live. R5's care plan last revised on 5/31/16, identified that R5 received hospice services and that hospice services would be available for the resident. The hospice plan of care dated 5/26/16, indicated R5 received skilled nursing visits one to two times weekly and as needed, social worker visits one to three times per month and as needed, aide visits five times per week, chaplain visits one to three times per month and as needed, and volunteer visits two to four times per month and as needed. During observation on 6/8/16, at 7:49 a.m. nursing assistant (NA)-D indicated she was aware R5 received hospice services because a hospice aide came everyday to assist her at lunch time. NA-D was unaware whether any other disciplines from hospice visited or when the visits occurred. During observation on 6/8/16, at 12:36 p.m. a hospice aide was noted to be assisting R5 to eat lunch.	F 309	Corrective action regarding R5 - conversation with Hospice agency to establish a clear coordination of services, including schedule for visiting hospice staff and documentation and communication of visit. No other residents identified at this time to be affected. To ensure that practice will not recur a hospice policy and procedure will be developed regarding coordination of services. Education to be provided to staff. To monitor for compliance, facility social worker/designee will randomly audit communication, documentation and schedule of hospice agency and report effectiveness at quarterly QA & A meetings.	

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F 309	Continued From page 12 When interviewed on 6/8/16, at 1:05 p.m. the social service designee (SSD) indicated she was aware the hospice nurse had been to the facility the prior day and that a hospice aide came Monday through Friday to assist R5 with her lunch. The SSD indicated the hospice providers gave a verbal report to staff with changes or updates and documented their visit in the chart. However, she was not sure of the hospice nurses' schedule nor when the next visit would occur. During interview on 6/8/16, at 1:06 p.m. licensed practical nurse (LPN)-A indicated a hospice aide came everyday at lunch time. LPN-A was unaware of the hospice nurse schedule and/or whether there was an established schedule of skilled nursing visits for R5. On 6/8/16, at 1:07 p.m. the director of nursing (DON) indicated she was unaware of the hospice skilled nursing visits for R5. The DON stated she did not know if there was a schedule communicated and coordinated with facility staff. On 6/9/16, at 1:31 p.m. hospice registered nurse (RN) case manager stated she visited R5 once weekly and "shoots for the first part of the week" and then named Monday, Tuesday and Wednesday. She then explained, Tuesday is her "target day". The hospice RN verified she did not provide a schedule nor coordinate visits with facility staff when she visited R5 but she would call the facility if she couldn't make a visit that week. A facility policy related to coordination of care with hospice was requested, but none was provided.	F 309		

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F 315	Continued From page 13	F 315		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess and identify appropriate interventions for 2 of 2 residents (R31, R28) reviewed for incontinence. Findings include: R31's admission Minimum Data Set (MDS) dated 12/17/16, indicated R31 was severely cognitively impaired, and experienced frequent incontinence of bladder requiring assistance with personal hygiene. R31's quarterly MDS dated 3/15/16, indicated a decline in incontinence as resident was always incontinent. R31's diagnoses noted on the care plan dated 1/25/16 included benign prostatic hypertrophy and dementia without behavioral symptoms. Review of the care area assessment (CAA) dated 12/17/15 indicated R31 had urinary urgency and needed assistance in toileting. The CAA further indicated urinary incontinence would be care	F 315	Corrective action for R31 - complete a bladder assessment and care plan problem with appropriate goal and interventions. Corrective action for R28 - complete a bladder assessment and review risks and benefits of ongoing catheter use and potential of removal with consideration of 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 significant changes. Education to be provided related to policy and procedure for completion of bladder assessment to ensure deficient practice doesn't recur.	7/8/16

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F 315	Continued From page 14 planned. However the CAA was incomplete and lacked analysis of the urinary incontinence to include identifying the type of incontinence in order to assist with developing appropriate interventions. During an interview on 6/9/16, at 12:28 p.m. the director of nurses (DON) was unable to locate a bladder assessment and indicated they do not do them. The DON would not identify when she would expect an urinary incontinence assessment to be done. A bladder incontinence policy was requested but not provided. R28 was admitted with an indwelling Foley catheter. The care plan dated 4/13/16, identified the rationale for the use of the catheter was impaired mobility, chronic pain, chemotherapy use and risk for skin breakdown. R28's admission Minimum Data Set (MDS) assessment dated 7/22/16, identified R28 with an indwelling Foley catheter. The MDS lacked a Care Area Assessment (CAA) related to urinary status which could address the continued use of the Foley catheter. R28's medical record lacked an assessment for urinary status related to the ongoing use of a foley catheter. There was no evidence of review of the risks & benefits of an indwelling catheter; the potential for removal of the catheter and consideration of complications resulting from the use of the indwelling foley catheter. The physician orders signed 5/31/16, identified R28's foley catheter should be changed monthly on the 24th and as needed. The physician orders did not identify the rationale for the use of the	F 315	DON or MDS LPN to randomly audit bladder assessments.	

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F 315	Continued From page 15 catheter. On 6/9/16, at 2:09 p.m. the director of nursing (DON) confirmed R28's medical record lacked a urinary assessment which included the rationale for the ongoing use of the catheter. The DON stated the closest reason she had for the use of the Foley catheter was, "she (R28) has a chronic foley catheter she came with."	F 315		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to assure dishes and utensils were cleaned under sanitary conditions. This had the potential to affect all 23 residents residing in the facility. Findings include: On 6/8/16, at 8:30 a.m. the dietary manager (DM) was observed to process dirty dishes through the dishwasher. The wash water temperature registered 100 degrees Fahrenheit. The DM again processed another load of dishes through	F 371	Corrective action - dishwasher repaired. Dietary staff instructed on recording temperature, what the appropriate temperature should be and when to notify maintenance and Dietary Manager if machine is not functioning at the correct temperature. Dishwasher Policy and Procedure revised to reflect manufacturer's guidelines. Dietary Manager to audit temp log sheet to make sure that temps are being logged	7/8/16

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F 371	Continued From page 16 the dish machine. The wash temperature again was noted to be registered at 100 degrees Fahrenheit. On 6/8/16, at 11:00 a.m. another load of soiled dishes was washed via the automated dishwasher and the water temperature at this time registered 100 degrees Fahrenheit. On 6/8/16, at 12:25 p.m. the wash temperature was 118 degrees. On 6/9/16, at 8:48 a.m. the wash temperature did not register a temperature higher than 100 degrees Fahrenheit. Two loads of dishes were observed to be run through the dishwasher. With each of these loads, staff pushed the fill button several times with each load. The temperature still did not go above 100 degrees Fahrenheit. These temperatures were verified by dietary aide (DA)-A. Review of the temperature logs for 4/16, 5/16. and 6/16, identified that temperatures for the breakfast wash cycle was at or above 120 degrees Fahrenheit 12 times during the past 3 months. The wash temperatures for the lunch and supper were measured at or above 120 degrees all but 5 times. During interview on 6/9/16, at 8:22 a.m. the DM identified the dishwasher was a chemical sanitation unit. She stated the wash cycle should be over 120 degrees. The DM stated the morning temperatures were always low and indicated it usually warmed up around 9:30 or 10:00 a.m.. She stated they were told to hit the fill button on the machine but staff have been doing this and it doesn't change the temperature. She stated she had brought this issue to the maintenance director in 3/16 or 4/16. The DM confirmed that with the chemical sanitation the wash cycle	F 371	and that the temps are appropriate based on manufacturer's recommendations. This issue will be reviewed at monthly Safety meeting and quarterly Quality Assurance meeting.	

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F 371	Continued From page 17 should be over 120 degrees Fahrenheit. During interview with the maintenance director on 6/9/16, at 8:55 a.m. he stated they have to hit the fill several times. When informed this did not work and the temperature remained low, he stated, "I guess I will have to look into it." A review of the dish machine product detail sheet provided by the facility identified that the operating temperature for the machine should be a minimum of 120 degrees Fahrenheit for the wash cycle.	F 371		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify	F 520		7/8/16

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F 520	Continued From page 18 and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the quality assessment and assurance (QAA) committee met quarterly as required and maintained required members. This had the potential to affect all 21 residents residing in the facility. Findings include: Review of the quality assurance meeting attendance logs from 6/9/15 to 6/9/16, identified the facility QAA committee met once on 3/23/16 and no further evidence provided of meetings held during this time period. The medical director did not attend the quarterly quality assurance meeting held 3/23/16. During interview on 6/9/16, at 3:30 p.m. the director of nursing (DON) explained the QAA met every 3 months but acknowledged there was only one attendance record of staff participating in the meeting. The DON explained she was new in her role and the 3/16 meeting was the first meeting she had attended. The DON verified there had been no action plans from 2015 that were reviewed and/or continued in 2016. The identified information was not available for review. The DON indicated there was also a new medical director. The DON indicated there were 3 different DON's and administrators in the administrative role during the past year.	F 520	Corrective action - Re-develop a Quality Assessment and Assurance committee. Policy and procedure developed to address committee requirements and purpose of committee. DON to set meeting dates, times, agendas and to notify committee members of meeting info. Committee members will be responsible for conducting surveys, audits, assessments, etc. to determine the root cause of issues that are brought forth to the committee and to work as a team to develop interventions to address the issue and report the effectiveness of the interventions. Education provided regarding P & P. To ensure ongoing compliance, minutes and member signature of attendance sheet to be completed with each meeting. Administrator to monitor QA & A system quarterly by attending meetings and reviewing content of materials discussed at meeting in relation to meeting committee's purpose and goals.	

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F 520	Continued From page 19 A quality assurance policy/procedure was requested but not provided.	F 520		

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	245315	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/08/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, 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 By email to:	K 000	EPOC	

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Trimont Healthcare Center was constructed as follows: The original building was constructed in 1963, is one-story, has a partial basement, is fully sprinklered and was determined to be of Type II(222) construction; The 1992 Chapel Addition is one-story, has no basement, is fully sprinklered and was determined to be of Type V(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. All Resident Rooms are equipped with single-station, battery-operated smoke alarms. The facility has a capacity of 36 beds and had a census of 23 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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K 021 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: (a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2 Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1 Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. This STANDARD is not met as evidenced by: Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: (a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2 Door assemblies in vertical openings are of an	K 021	Contacted electrician to wire magnetic hold open device to fire alarm system. Proposed date of completion 7/15/16. Maintenance Director to monitor for completion.	7/15/16

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K 021	Continued From page 3 approved type with appropriate fire protection rating. 8.2.3.2.3.1 Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. FINDINGS INCLUDE: On 06/08/2016 between the hours of 9:00am to 6:30pm, observation revealed the Kitchen Serving Door was observed being held open by a magnetic hold open device that is not connected to the fire alarm system that would release the door upon fire alarm activation. This finding was verified with the maintence supervisor at the time of discovery.	K 021		
K 022 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. Doors, passages or stairways that are not a way of exit that are likely to be mistaken for an exit have a sign designating "No Exit". 7.10, 18.2.10.1, 19.2.10.1 This STANDARD is not met as evidenced by: Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. Doors, passages or stairways that are not a way of exit that are likely to be mistaken for an exit have a sign designating "No Exit". 7.10, 18.2.10.1, 19.2.10.1 FINDINGS INCLUDE: On 06/08/2016 between the hours of 9:00am to 6:30pm, observation revealed the door from the	K 022	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.	6/20/16

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	245315	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/08/2016**

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K 022	Continued From page 4 Dining room to the Courtyard is not being considered as a exit and therefore it should be labeled "No Exit" and the Chapel Exit Door is considered a exit and therefore the "No Exit" sign needs to be removed. This finding was verified with the maintence supervisor at the time of discovery.	K 022		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 FINDINGS INCLUDE: During Facility Inspection on June 08, 2016, between 09:00 AM and 6:30 PM, observation during the inspection revealed the following	K 029	01) O2 room door - closure installed on the door by maintenance on 6/30/16. 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. 03) Housekeepers Cart room door - closure to be installed on the door by 7/15/16. Wall penetrations were sealed on 6/21/16. 04) Generator room door - latch repaired on 6/28/16 by maintenance.	7/15/16

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K 029	Continued From page 5 discrepancies with Hazardous Areas: 01.) The oxygen storage room door in the south hallway was observed without a self closing device on the door. 02.) The kitchen storage room door was observed being held open with a wooden wedge. 03.) The housekeepers cart room door was observed without a self closing device on the door and wall penetrations around cables not properly sealed. 04.) The generator room door was observed not being able to positively latch into the door frame and wall penetrations not properly sealed. 05.) The crawl space access door in the boiler room was observed being held open by a wire. 06.) Wall penetrations were observed not properly sealed in the boiler room. 07.) The door on the old incinerator room was observed not being able to positively latch into the door frame. 08.) The old salt room/storage room was observed without a self closing device on the door. 09.) Wall penetrations into the corridor from the generator room around the lp gas line and electrical conduit was observed without being properly sealed. 10.) The door on the ventilator/storage room in the kitchen was observed without a self closing device. 11.) Penetrations around fire sprinkler pipe and electrical conduit was observed in the chapel mechanical room. NOTE: All Hazardous Areas need to be checked to ensure compliance. These deficient practices were observed by the Maintenance Director.	K 029	05) Crawl space access door - wire that was holding door open was removed by maintenance on 6/21/16. 06) Wall penetrations in boiler room were sealed by maintenance on 6/28/16. 07) Door on old incinerator room - door to be repaired so it positively latches into the door frame by maintenance by 7/15/16. 08) Old salt room/storage room - closure to be installed by maintenance by 7/15/16. 09) Wall penetrations were sealed by maintenance 6/21/16. 10) Door on ventilator/storage room in kitchen - closure to be installed by maintenance by 7/15/16. 11) Penetrations around sprinkler pipe and electrical conduit in chapel mechanical room was sealed on 6/23/16. All hazardous areas maintained by Maintenance Director.	

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K 033 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit enclosures (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 7.1.3.2, 8.2.5.2, 8.2.5.4, 19.3.1.1 This STANDARD is not met as evidenced by: Exit enclosures (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 7.1.3.2, 8.2.5.2, 8.2.5.4, 19.3.1.1 FINDINGS INCLUDE: During Facility Inspection on June 08, 2016, between 09:00 AM and 6:30 PM, observation during the inspection revealed the following discrepancies: 01.)The door on the time card stairwell was observed not being able to latch into the door frame. 02.) Wall penetrations were observed in the southwest stairwell not being properly sealed. These deficient practices were observed by the Maintenance Director.	K 033	01) Door on the timecard stairwell to have closure installed by maintenance by 7/15/16. 02) Wall penetrations in SW stairwell sealed by maintenance on 6/23/16. Both discrepancies to be monitored by the Maintenance Director.	7/15/16
K 034 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4 This STANDARD is not met as evidenced by: Stairways and smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4	K 034	Handrail was installed within the descending side of the SW stairwell by maintenance on 6/28/16.	6/28/16

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K 034	Continued From page 7 FINDINGS INCLUDE: During Facility Inspection on June 08, 2016, between 09:00 AM and 6:30 PM, observation during the inspection revealed the following discrepancy: No handrail was observed within the descending side on the southwest stairwell exit. This deficient practice was observed by the Maintenance Director.	K 034	Handrails to be maintained by maintenance.	
K 047 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1 (Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is not met as evidenced by: Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1 (Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) FINDINGS INCLUDE: During Facility Inspection on June 08, 2016, between 09:00 AM and 6:30 PM, observation during the inspection revealed the following discrepancies: Illuminated exit signs were not observed in the following areas:	K 047	01) Illuminated exit signs placed at N & S exits from dining room by maintenance on 6/22/16. 02) Illuminated exit signs placed from kitchen into dining room and exit from kitchen near freezer by maintenance on 6/22/16. 03) Illuminated exit from lower level to timecard stairwell to be placed by maintenance by 7/15/16. 04) Illuminated exit from lower level to SW stairwell to be placed by 7/15/16 by maintenance.	7/15/16

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K 047	Continued From page 8 01.) North and south exits from the dining room. 02.) Exit from the kitchen into the dining room and the exit from the kitchen near the freezer 03.) Exit from the lower level to the time card stairwell. 04.) Exit from the lower level to the southwest stairwell. These deficient practices were observed by the Maintenance Director.	K 047	Maintenance of illuminated exits to be maintained and monitored by the Maintenance Director.	
K 050 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2	K 050	Quarterly fire drills will be conducted at varied times on varied shifts. Fire drills will be documented by the Maintenance Director and the Administrator will randomly audit the documentation for compliance.	6/29/16

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K 050	Continued From page 9 FINDINGS INCLUDE: During Facility Inspection on June 08, 2016, between 09:00 AM and 6:30 PM, documentation review revealed quarterly fire drills were observed not being conducted at varied times throughout the year: Day shift (7am-3pm) 1st quarter fire drill @12:51pm and 2nd quarter fire drill @ 1:04pm. Evening shift (3pm-11pm) 1st quarter fire drill @ 4:25pm and 2nd quarter fire drill @ 4:50pm. These deficient practices were observed by the Maintenance Director.	K 050		
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available.	K 051		7/15/16

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K 051	Continued From page 10 18.3.4, 19.3.4, 9.6 This STANDARD is not met as evidenced by: A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6 FINDINGS INCLUDE: During Facility Inspection on June 08, 2016, between 09:00 AM and 6:30 PM, observation during the inspection revealed the following discrepancy: The staff on-call sleeping area in the lower level was observed without a smoke detector connected into the main fire alarm system and without a sounder board in the immediate area. This deficient practice was observed by the	K 051	Staff on-call sleeping area in lower level will have a smoke detector installed that is connected into the main fire alarm with a sounder board by 7/15/16. Maintenance Director to monitor for compliance with installation	

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K 051	Continued From page 11 Maintenance Director.	K 051		
K 053 SS=E	NFPA 101, 483.70(a)(7) LIFE SAFETY CODE STANDARD In an existing nursing home, not fully sprinklered, the resident sleeping rooms and public areas (dining rooms, activity rooms, resident meeting rooms, etc) are to be equipped with single station battery-operated smoke detectors. There will be a testing, maintenance and battery replacement program to ensure proper operation. 42 CFR 483.70(a)(7) This STANDARD is not met as evidenced by: In an existing nursing home, not fully sprinklered, the resident sleeping rooms and public areas (dining rooms, activity rooms, resident meeting rooms, etc) are to be equipped with single station battery-operated smoke detectors. There will be a testing, maintenance and battery replacement program to ensure proper operation. 42 CFR 483.70(a)(7) FINDINGS INCLUDE: During Facility Inspection on June 08, 2016, between 09:00 AM and 6:30 PM, during documentation review it was revealed that the battery operated smoke detector in the media center was not tested January through May 2016. This deficient practice was observed by the Maintenance Director.	K 053	Smoke detector in the Media Center was tested and battery replaced on 6/30/16. This battery operated smoke detector will be replaced with a smoke detector that will be connected into the main fire alarm system by 7/15/16. Installation and monitoring of compliance will be completed by the Maintenance Director.	7/15/16
K 054 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved,	K 054		6/27/16

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K 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: During Facility Inspection on June 08, 2016, between 09:00 AM and 6:30 PM, during documentation review of the annual fire alarm inspection/smoke detector sensitivity report it was revealed that the corridor smoke detector near room 105 was not tested due to being unaccessible with its location directly above the fire sprinkler pipe. This deficient practice was verfied by the Maintenance Supervisor.	K 054	Corridor smoke detector near room 105 was moved for easier accessibility for testing. Maintenance Director to monitor testing of smoke detector.	
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system 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 This STANDARD is not met as evidenced by: Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system	K 056	01) Items stored on fire sprinkler pipe in maintenance office removed on 6/27/16. Maintenance Director to monitor that	7/15/16

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K 056	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.	K 056	items are not placed on sprinkler pipes in the future. 02) Sprinkler head at top of dirty linen chute to be replaced by Simplex by 7/15/16. 03) Fire sprinkler head to be installed by Simplex in the storage closet in the kitchen by 7/15/16. 04) Fire sprinkler head to be installed in the storage closet in the dining room by Simplex by 7/15/16. Maintenance Director to monitor that installation is completed - Simplex has been contacted to come in and do the installation.	
K 062 SS=D	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, 9.7.5 This STANDARD is not met as evidenced by: Required automatic sprinkler systems are	K 062	Drop ceiling tiles in media center were	6/22/16

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K 062	Continued From page 14 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 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: Two drop-in ceiling tiles were observed missing in the media center.These missing ceiling tiles will adversing affect the operation of the nearby fire sprinkler heads. This deficient practice was verfied by the Maintenance Supervisor.	K 062	put back in place on 6/22/16. Maintenance Director to ensure that placement of tiles is appropriate.	
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 This STANDARD is not met as evidenced by: Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 FINDINGS INCLUDE: During Facility Inspection on June 08, 2016, between 09:00 AM and 6:30 PM, the following	K 064	Fire extinguishers in laundry room and lower level corridor placed on hooks on 6/8/16. Proper placement of extinguishers will be monitored by the Maintenance Director.	6/8/16

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	245315	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/08/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIMONT HEALTH CARE CENTER	**303 BROADWAY AVENUE SOUTH** **TRIMONT, MN 56176**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 064	Continued From page 15 deficiency was observed: A fire extinguisher in the laundry and a fire extinguisher in the lower level corridor were observed not being stored on wall hooks or fire extinguisher cabinets. These deficient practices were verfied by the Maintenance Supervisor.	K 064		
K 070 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F (100 degrees C). 18.7.8, 19.7.8 This STANDARD is not met as evidenced by: Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F (100 degrees C). 18.7.8, 19.7.8 FINDINGS INCLUDE: During Facility Inspection on June 08, 2016, between 09:00 AM and 6:30 PM, during documentation review, it was revealed that a written policy that prohibits the use of portable space heaters was available for review. This deficient practice was observed by the Maintenance Director.	K 070	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 staff to read. Compliance will be monitored by the Safety Committee monthly.	6/30/16
K 072	NFPA 101 LIFE SAFETY CODE STANDARD	K 072		6/8/16

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	245315	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/08/2016**

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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. FINDINGS INCLUDE: During Facility Inspection on June 08, 2016, between 09:00 AM and 6:30 PM, the following deficiency was observed: A chair was observed being stored within the southwest stairwell exit. This deficient practice was observed by the Maintenance Director.	K 072	Chair in SW stairwell exit removed on 6/8/16. Staff educated not to place any items in a stairwell. Maintenance Director to monitor for obstacles in the stairwell and removal of any obstacles.	
K 074 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations are flame resistant in accordance with NFPA 701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in accordance with NFPA 13 to avoid obstruction of the sprinkler. 10.3.1, 18.3.5.5, 19.3.5.5, 18.7.5.1, 19.7.5.1, NFPA 13	K 074		7/15/16

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	245315	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/08/2016**

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K 074	Continued From page 17 o Newly introduced upholstered furniture shall meet the char length and heat release criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3, 18.7.5.2, 19.7.5.2. o Newly introduced mattresses shall meet the char length and heat release criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3 o Newly introduced upholstered furniture and mattresses means purchased since March, 2003. This STANDARD is not met as evidenced by: Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations are flame resistant in accordance with NFPA 701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in accordance with NFPA 13 to avoid obstruction of the sprinkler. 10.3.1, 18.3.5.5, 19.3.5.5, 18.7.5.1, 19.7.5.1, NFPA 13 o Newly introduced upholstered furniture shall meet the char length and heat release criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3, 18.7.5.2, 19.7.5.2. o Newly introduced mattresses shall meet the char length and heat release criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3 o Newly introduced upholstered furniture and mattresses means purchased since March, 2003. FINDINGS INCLUDE:	K 074	Privacy curtains to be treated with Flame Stop I retardant by 7/15/16 and items documented when completed by the Maintenance Director. Safety Committee to ensure that curtains, draperies, loosely hanging fabrics and films serving as furnishings or decorations are flame resistant.	

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K 074	Continued From page 18 During Facility Inspection on June 08, 2016, between 09:00 AM and 6:30 PM, during documentation review, it was revealed that there was no documentation for the privacy curtains being used within the resident rooms to show that the curtains met NFPA 701. This deficient practice was observed by the Maintenance Director.	K 074		
K 076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4 This STANDARD is not met as evidenced by: Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4 FINDINGS INCLUDE: During Facility Inspection on June 08, 2016,	K 076	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 the need for O2 tanks to be stored securely.	6/23/16

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K 076	Continued From page 19 between 09:00 AM and 6:30 PM, one oxygen e-cylinder was observed being stored in the oxygen storage room without being chained or within a storage rack that would prevent the cylinder from falling over. This deficient practice was observed by the Maintenance Director.	K 076		
K 144 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) FINDINGS INCLUDE: During Facility Inspection on June 08, 2016, between 09:00 AM and 6:30 PM, during documentation review, it was revealed that the cool down time was not being documented on the monthly generator test report. This deficient practice was observed by the Maintenance Director.	K 144	Generator test report was revised to indicate cool down time. Maintenance Director responsible to document cool down time.	6/30/16
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2	K 147		6/29/16

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K 147	Continued From page 20 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 FINDINGS INCLUDE: During Facility Inspection on June 08, 2016, between 09:00 AM and 6:30 PM, the following electrical deficiencies were observed: 01.) The power strip in Resident room 106 was exposed wires at the plug. 02.) The power cord on the kitchen freezer was exposed wires at the the plug. 03.) The window air conditioning unit was observed plugged into a power strip in the medical records office. 04.) An extension cord in the generator room was observed being used as a source for fixed wiring. 05.) Wall conduit in the ventilator/mechanical room in the kitchen has exposed wiring. 06.) Power strips were observed being used as a source of fixed wiring in 18 out of 21 resident rooms. These deficient practices were observed by the Maintenance Director.	K 147	01) Power strip in resident room 106 was removed on 6/28/16. 02) Power cord on kitchen freezer was repaired on 6/29/16. 03) Window A/C unit in medial record office unplugged from power strip and plugged into appropriate outlet on 6/20/16. 04) Extension cord in generator room was removed on 6/21/16. 05) Wall conduit in ventilator/mechanical room in kitchen was repaired 6/28/16. 06) Power strips in resident rooms were removed on 6/28/16. All electrical deficiencies resolved by maintenance department and continued monitoring of electrical compliance will be completed by Maintenance Director.	

Minnesota Department of Health

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00365	A. BUILDING: _____ B. WING _____	06/09/2016

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TRIMONT HEALTH CARE CENTER	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On June 6-9, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the quality assessment and assurance (QAA) committee met quarterly as required and maintained required members. This had the potential to affect all 21 residents residing in the facility. Findings include: Review of the quality assurance meeting attendance logs from 6/9/15 to 6/9/16, identified the facility QAA committee met once on 3/23/16	2 255	Corrected.	7/8/16

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2 255	Continued From page 3 and no further evidence provided of meetings held during this time period. The medical director did not attend the quarterly quality assurance meeting held 3/23/16. During interview on 6/9/16, at 3:30 p.m. the director of nursing (DON) explained the QAA met every 3 months but acknowledged there was only one attendance record of staff participating in the meeting. The DON explained she was new in her role and the 3/16 meeting was the first meeting she had attended. The DON verified there had been no action plans from 2015 that were reviewed and/or continued in 2016. The identified information was not available for review. The DON indicated there was also a new medical director. The DON indicated there were 3 different DON's and administrators in the administrative role during the past year. A quality assurance policy/procedure was requested but not provided. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to ensure the quality assurance (QA) committee includes the required members and meets once every quarter to ensure ongoing compliance. The administrator or designee could educate all appropriate staff on these policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 255		

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2 540	Continued From page 4	2 540		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess and identify appropriate interventions for 2 of 2	2 540	Corrected.	7/8/16

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 540	Continued From page 5 residents (R31, R28) reviewed for incontinence and 1 of 1 residents (R31) reviewed for wandering. Findings include: R31's admission Minimum Data Set (MDS) dated 12/17/16, indicated R31 was severely cognitively impaired, and experienced frequent incontinence of bladder requiring assistance with personal hygiene. R31's quarterly MDS dated 3/15/16 indicated resident was always incontinent which indicated a decline in continence. The MDS also indicated R31 was at risk for wandering to a dangerous place. Review of the 7 day behavior look back dated 12/11/15 indicated R31 had wandered which placed R31 at risk of danger on 12/15/15 and 12/16/15. R31's diagnoses noted on the care plan dated 1/25/16 included benign prostatic hypertrophy and dementia without behavioral symptoms. Review of the care area assessment (CAA) dated 12/17/15, indicated R31 had urinary urgency and needed assistance in toileting. The CAA further indicated urinary incontinence would be care planned. However the CAA was incomplete and lacked analysis of the urinary incontinence to include identifying the type of incontinence in order to assist with developing appropriate interventions. During an interview on 6/9/16, at 12:28 p.m. the director of nurses (DON) was unable to locate a bladder assessment and indicated they do not do them. The DON would not identify when she would expect an urinary incontinence assessment to be done.	2 540		

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2 540	Continued From page 6 The CAA dated 12/17/15, also indicated R31 was at immediate threat to self and had wandered in the past 7 days. The CAA worksheet was incomplete and lacked comprehensive assessment, analysis or interventions developed regarding incontinence or wandering and indicated these issues would be care planned. During review of the admission progress notes dated 12/7/15, the social worker (SW) notes indicated R31 was a known wanderer. The notes further indicated R31 was alert, oriented, able to communicate needs with no behavior indicators present upon referral. During an interview on 6/7/16, at 2:57 p.m. the social worker (SW) indicated the resident had not demonstrated any wandering at the facility. SW further indicated R31 had 2 episodes of wandering within the first weeks of admission. The SW reported R31 wandered into another resident's room twice but is now immobile in the wheelchair. The SW reported a wanderguard was not placed initially as he was not exit seeking but looking for his room. The SW further indicated R31 did not have an elopement risk assessment completed upon admission. On 6/8/16, at 8:20 a.m. the administrator reported the resident had been in an assisted living facility and was noted to wander while there. R31 needed different placement due to limited staff to redirect when wandering. The adminstrator indicated she was not aware if a 24-48 hour assessment was completed and further indicated she would expect one to have been done. The adminstrator indicated she would have expected a wanderguard to be placed and watch the resident and observe the behavior especially if they were a known wanderer.	2 540		

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2 540	Continued From page 7 On 6/9/16 at 12:28 p.m. the director of nurses (DON) indicated she was unaware of an elopement assessment being completed and could not provide any further information. The Elopement policy with a review date of 8/18/08, indicated during the admission process all residents would be assessed for the their risk of elopement. R28 was admitted with an indwelling Foley catheter. The care plan dated 4/13/16, identified the rationale for the use of the catheter was impaired mobility, chronic pain, chemotherapy use and risk for skin breakdown. R28's admission Minimum Data Set (MDS) assessment dated 7/22/16, identified R28 with an indwelling Foley catheter. The MDS lacked a Care Area Assessment (CAA) related to urinary status which could address the continued use of the Foley catheter. R28's medical record lacked an assessment for urinary status related to the ongoing use of a foley catheter. There was no evidence of assessment of the risks & benefits of an indwelling catheter; the potential for removal of the catheter and consideration of complications resulting from the use of the indwelling foley catheter. On 6/9/16, at 2:09 p.m. the director of nursing (DON) confirmed R28's medical record lacked a urinary assessment which included the rationale for the ongoing use of the catheter. The DON stated the closest reason she had for the use of the Foley catheter was, "she (R28) has a chronic foley catheter she came with."	2 540		

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2 540	Continued From page 8 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure resident MDS assessments are comprehensive. Education could be provided to all appropriate staff and a monitoring system could be developed to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 540		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to develop a comprehensive care plan related to dental care for 1 of 3 (R18) residents reviewed for dental services. Findings include: R18 had a diagnosis of dementia. On 6/6/16, at 6:39 p.m. resident was noted to be missing all of her teeth on top and had only two visible teeth on	2 560	Corrected	7/15/16

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2 560	Continued From page 9 her lower gum lines. She did not have any dentures/partials in the mouth. The admission Minimum Data Set (MDS) dated 3/7/16, identified R18 as having a BIMS (Brief Interview for Mental Status) score of 4 indicating severe cognitive impairment and needing extensive assistance of one staff member with personal hygiene. Furthermore, it identified R18 as having obvious or likely cavity or broken natural teeth. The Care Area Assessment (CAA) dated 3/7/16, identified that dental care would be addressed in the care plan. Review of R18's care plan with last revision date of 6/8/16, did not include any ADL or self care deficit problems, goals, or interventions related to the management of dental care. During interview on 6/9/16, at 10:15 a.m. nursing assistant (NA)-B stated R18 had an upper denture but refused to wear it. NA-B further stated R18 needed assistance to complete her oral/dental cares each day. During interview on 6/9/16, at 11:07 a.m. the director of nursing (DON) confirmed the careplan did not include a dental/oral care plan, but should have. However, the DON stated the nursing assistants use the care plan on the kiosk for cares. Dental care problems, goals, and interventions were visible there. During interview on 6/9/16, at 11:26 a.m. NA-E verified that no oral/dental plan of care existed on the kiosk for R18. Review of Trimont Health Care Center Policy and Procedures for Care Plan Conference & Care plan requirements revised 6/9/10, directed staff to	2 560		

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2 560	Continued From page 10 develop an individualized comprehensive care plan that would include dental condition. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to the care plan. The DON or designee, could provide training for all nursing staff related to the development of the care plan based on the assessment. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure services were coordinated with the hospice agency for 1 of 1	2 830	Corrected.	7/8/16

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2 830	Continued From page 11 residents (R5) reviewed for hospice. Findings include: R5's significant change Minimum Data Set (MDS) assessment dated 2/23/16, identified R5 as cognitively intact, required extensive assistance with activities of daily living (ADL), and had a prognosis of less than 6 months to live. R5's care plan last revised on 5/31/16, identified that R5 received hospice services and that hospice services would be available for the resident. The hospice plan of care dated 5/26/16, indicated R5 received skilled nursing visits one to two times weekly and as needed, social worker visits one to three times per month and as needed, aide visits five times per week, chaplain visits one to three times per month and as needed, and volunteer visits two to four times per month and as needed. During observation on 6/8/16, at 7:49 a.m. nursing assistant (NA)-D indicated she was aware R5 received hospice services because a hospice aide came everyday to assist her at lunch time. NA-D was unaware whether any other disciplines from hospice visited or when the visits occurred. During observation on 6/8/16, at 12:36 p.m. a hospice aide was noted to be assisting R5 to eat lunch. When interviewed on 6/8/16, at 1:05 p.m. the social service designee (SSD) indicated she was aware the hospice nurse had been to the facility the prior day and that a hospice aide came Monday through Friday to assist R5 with her	2 830		

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2 830	Continued From page 12 lunch. The SSD indicated the hospice providers gave a verbal report to staff with changes or updates and documented their visit in the chart. However, she was not sure of the hospice nurses' schedule nor when the next visit would occur. During interview on 6/8/16, at 1:06 p.m. licensed practical nurse (LPN)-A indicated a hospice aide came everyday at lunch time. LPN-A was unaware of the hospice nurse schedule and/or whether there was an established schedule of skilled nursing visits for R5. On 6/8/16, at 1:07 p.m. the director of nursing (DON) indicated she was unaware of the hospice skilled nursing visits for R5. The DON stated she did not know if there was a schedule communicated and coordinated with facility staff. On 6/9/16, at 1:31 p.m. hospice registered nurse (RN) case manager stated she visited R5 once weekly and "shoots for the first part of the week" and then named Monday, Tuesday and Wednesday. She then explained, Tuesday is her "target day". The hospice RN verified she did not provide a schedule nor coordinate visits with facility staff when she visited R5 but she would call the facility if she couldn't make a visit that week. A facility policy related to coordination of care with hospice was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies related to the coordination of hospice services. The DON or designee could educate all appropriate staff and outside vendors on those policies. The DON or designee could monitor to ensure ongoing	2 830		

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2 830	Continued From page 13 compliance, and review results with the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess and identify appropriate interventions for 2 of 2 residents (R31, R28) reviewed for incontinence. Findings include: R31's admission Minimum Data Set (MDS) dated 12/17/16, indicated R31 was severely cognitively impaired, and experienced frequent incontinence	2 910	Corrected.	7/8/16

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2 910	Continued From page 14 of bladder requiring assistance with personal hygiene. R31's quarterly MDS dated 3/15/16, indicated a decline in incontinence as resident was always incontinent. R31's diagnoses noted on the care plan dated 1/25/16 included benign prostatic hypertrophy and dementia without behavioral symptoms. Review of the care area assessment (CAA) dated 12/17/15 indicated R31 had urinary urgency and needed assistance in toileting. The CAA further indicated urinary incontinence would be care planned. However the CAA was incomplete and lacked analysis of the urinary incontinence to include identifying the type of incontinence in order to assist with developing appropriate interventions. During an interview on 6/9/16, at 12:28 p.m. the director of nurses (DON) was unable to locate a bladder assessment and indicated they do not do them. The DON would not identify when she would expect an urinary incontinence assessment to be done. A bladder incontinence policy was requested but not provided. R28 was admitted with an indwelling Foley catheter. The care plan dated 4/13/16, identified the rationale for the use of the catheter was impaired mobility, chronic pain, chemotherapy use and risk for skin breakdown. R28's admission Minimum Data Set (MDS) assessment dated 7/22/16, identified R28 with an indwelling Foley catheter. The MDS lacked a Care Area Assessment (CAA) related to urinary status which could address the continued use of the Foley catheter. R28's medical record lacked an assessment for urinary status related to the ongoing use of a foley catheter. There was no	2 910		

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2 910	Continued From page 15 evidence of review of the risks & benefits of an indwelling catheter; the potential for removal of the catheter and consideration of complications resulting from the use of the indwelling foley catheter. The physician orders signed 5/31/16, identified R28's foley catheter should be changed monthly on the 24th and as needed. The physician orders did not identify the rationale for the use of the catheter. On 6/9/16, at 2:09 p.m. the director of nursing (DON) confirmed R28's medical record lacked a urinary assessment which included the rationale for the ongoing use of the catheter. The DON stated the closest reason she had for the use of the Foley catheter was, "she (R28) has a chronic foley catheter she came with." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for incontinence to assure they are receiving the necessary treatment/services to prevent/minimize incontinence. The DON or designee, could educate all appropriate staff on the appropriate provision of services for incontinence. The DON or designee could conduct random audits to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in	21015		7/8/16

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21015	Continued From page 16 the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to assure dishes and utensils were cleaned under sanitary conditions. This had the potential to affect all 23 residents residing in the facility. Findings include: On 6/8/16, at 8:30 a.m. the dietary manager (DM) was observed to process dirty dishes through the dishwasher. The wash water temperature registered 100 degrees Fahrenheit. The DM again processed another load of dishes through the dish machine. The wash temperature again was noted to be registered at 100 degrees Fahrenheit. On 6/8/16, at 11:00 a.m. another load of soiled dishes was washed via the automated dishwasher and the water temperature at this time registered 100 degrees Fahrenheit. On 6/8/16, at 12:25 p.m. the wash temperature was 118 degrees. On 6/9/16, at 8:48 a.m. the wash temperature did not register a temperature higher than 100 degrees Fahrenheit. Two loads of dishes were observed to be run through the dishwasher. With each of these loads, staff pushed the fill button several times with each load. The temperature still did not go above 100 degrees Fahrenheit. These temperatures were verified by dietary aide (DA)-A. Review of the temperature logs for 4/16, 5/16. and 6/16, identified that temperatures for the	21015	Corrected.	

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21015	Continued From page 17 breakfast wash cycle was at or above 120 degrees Fahrenheit 12 times during the past 3 months. The wash temperatures for the lunch and supper were measured at or above 120 degrees all but 5 times. During interview on 6/9/16, at 8:22 a.m. the DM identified the dishwasher was a chemical sanitation unit. She stated the wash cycle should be over 120 degrees. The DM stated the morning temperatures were always low and indicated it usually warmed up around 9:30 or 10:00 a.m.. She stated they were told to hit the fill button on the machine but staff have been doing this and it doesn't change the temperature. She stated she had brought this issue to the maintenance director in 3/16 or 4/16. The DM confirmed that with the chemical sanitation the wash cycle should be over 120 degrees Fahrenheit. During interview with the maintenance director on 6/9/16, at 8:55 a.m. he stated they have to hit the fill several times. When informed this did not work and the temperature remained low, he stated, "I guess I will have to look into it." A review of the dish machine product detail sheet provided by the facility identified that the operating temperature for the machine should be a minimum of 120 degrees Fahrenheit for the wash cycle. SUGGESTED METHOD OF CORRECTION: The dietary manager (DM) could develop policies and procedures regarding safe dishwasher operating temperatures based off the manufacturer's recommendations and guidelines. This could include a system for notification and repair of equipment in a timely manner. The DM could educate all appropriate staff on these policies.	21015		

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21015	Continued From page 18 The DM could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a Tuberculosis (TB) prevention and control program included a TB symptom screening of all newly hired employees and residents and included a two step tuberculin skin test (TST) for 5 of 5 employees (nursing assistant (NA)-F, NA-G, NA-H, maintenance (M)-A, housekeeper (H)-A) and 5 of 5 residents (R21, R31, R33, R35, R37). Findings Include: MA-A, whose hire date was 5/23/16, received the first administration of the tuberculin skin test (TST) on 5/23/16. The symptom screen and second TST were not completed or administered. H-A, with a hire date of 5/2/16, received the first administration of the TST on 5/2/16. The symptom screen and second TST were not completed or administered.	21375	Corrected.	7/8/16

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21375	Continued From page 19 NA-F, with a hire date of 1/4/16, received the first administration of the TST on 1/4/16. The symptom screen and second TST were not completed or administered. NA-G, whose hire date was 5/13/16, received the first administration of the TST on 5/13/16. The symptom screen and second TST were not completed or administered. NA-H, whose hire date was 12/21/15, received the first administration of the TST on 12/21/15. The symptom screen and second TST were not completed or administered. R35, admission date of 3/15/16, received the first administration of the TST on 4/1/16. The symptom screen and second TST were not completed or administered. R21, admission date of 3/22/16, received the first administration of the TST on 4/8/16. The symptom screen and second TST were not completed or administered. R33, admission date 2/9/16, received the first and second administration of the TST on 2/10/16 and 2/24/16. The symptom screen was not completed. R31, admission date 12/7/15, received the first and second administration of the TST on 12/8/15 and 12/22/15. The symptom screen was not completed. R37, admission date 4/7/16, received the first and second administration of the TST on 4/8/16 and 4/22/16. The symptom screen was not completed.	21375		

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21375	Continued From page 20 During an interview on 6/7/16, at 11:00 a.m. the administrator verified the 2 step TB testing was not completed according to the TB regulations for residents and employees newly hired/admitted. The policy and procedure Mantoux Testing Two Step for Employees, review date 5/14/10, indicated the first of the two step TB test (Mantoux) would be done prior to the employees start date and a second Mantoux would be repeated in 2 weeks. The policy and procedure Mantoux-Resident, review date 5/7/07, indicated all residents were required to have a two-step Mantoux on admission and a second TST should be administered 10-14 days after the first. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review and revise policies and procedures related to the components of the infection control and TB monitoring program. Facility staff could be educated on the TB regulations and the two step Mantoux process. The director of nursing and/or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one-(21) days.	21375		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right	21830		7/8/16

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21830	Continued From page 21	21830		

includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences.

(b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the resident;

(2) examining the medical records of the resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a

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21830	Continued From page 22 physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.	21830		

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21830	Continued From page 23 This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to accommodate bathing choices for 2 of 3 residents (R35, R28) reviewed for choices. Findings include: R35 stated on 6/6/16, at 3:31 p.m. that she was not offered a choice in how many times a week (frequency) she received a bath/shower. She stated, "everyone gets one a week, that's what they told me when I came in here." When asked if she thought she could have more than one bath or shower per week she stated, "Nope you can't. They said everyone gets one a week and that's it." During an subsequent interview on 6/7/16, at 1:56 p.m. R35 stated "they tell you when you come in you can only have one bath". On 6/9/16, at 11:49 p.m. R35 stated she had never asked for more than one bath as she was told you can only have one. She stated, "I would like more than one especially now that it is getting hot out." Review of the admission Minimum Data Set (MDS) assessment dated 3/22/16, identified R35 had a Brief Interview for Mental Status (BIMS) score of 15/15, indicating intact cognition. Review of the admission nursing assessment dated 3/15/16, identified that R35 preferred to take an a.m. (morning) bath. It did not identify whether R35 desired more than one bath a week. R28 stated on 6/6/16, at 6:01 p.m., that everyone gets "one bath a week, that's what they told me".	21830	Corrected.	

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21830	Continued From page 24 On 6/9/16, at 11:49 a.m., R28 again stated that when she was admitted facility staff told her, "we do one bath a week here". She indicated she had never requested another bath as she was told she could only have one. She stated it would be nice to get more than one bath a week. The MDS dated 12/29/16, identified R28 with a BIMS score of 15/15, indicating intact cognition. Review of the admission nursing assessment did not identify R28's preference for bathing frequency. During interview on 6/9/16, at 12:35 p.m. nursing 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."	21830		

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21830	Continued From page 25 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could development and implement policies and procedures to ensure all residents are offered choices in their daily routines. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could monitor to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21830		
21915	MN St. Statute 144.651 Subd. 27 Patients & Residents of HC Fac.Bill of Rights Subd. 27. Advisory councils. Residents and their families shall have the right to organize, maintain, and participate in resident advisory and family councils. Each facility shall provide assistance and space for meetings. Council meetings shall be afforded privacy, with staff or visitors attending only upon the council's invitation. A staff person shall be designated the responsibility of providing this assistance and responding to written requests which result from council meetings. Resident and family councils shall be encouraged to make recommendations regarding facility policies. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to attempt to organize a family council on at least an annual basis. This had the potential to affect all 23 resident families who reside in the facility. Findings include:	21915	Corrected.	6/28/16

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21915	Continued From page 26 During interview on 6/6/16, at 2:30 p.m. social service designee (SSD) confirmed the facility did not have an existing family council. The SSD further confirmed she had not formally attempted to organize a family council in the past year stating she was unaware of this requirement. A facility policy on family council was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The administrator or designee could ensure thorough attempts are made to develop a family council. The administrator or designee could develop monitoring systems to ensure thorough attempts are made to initiate the family council. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21915		