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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: E33Y
Facility ID: 00073

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245499**

2. STATE VENDOR OR MEDICAID NO. (L2) **190176100**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **07/01/2004**

6. DATE OF SURVEY 10/28/2013 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

12. Total Facility Beds **50** (L18)

13. Total Certified Beds **50** (L17)

10. THE FACILITY IS CERTIFIED AS:

A. In Compliance With
Program Requirements
Compliance Based On:
____1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Post Certification Revisit, by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective October 24, 2013, the facility is certified for 50 skilled nursing facility beds.

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 11/8/2013
(L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 12/27/2013
(L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

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

25. LTC EXTENSION DATE:
(L27)

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/15/2013
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5499 December 27, 2013

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

Dear Ms. Rauk:

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

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

Effective October 24, 2013, the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900, St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

November 8, 2013

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

RE: Project Number S5499020

Dear Ms. Rauk:

On September 26, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 12, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F)whereby corrections were required.

On October 28, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 26, 2013 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 12, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 24, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 12, 2013, effective October 24, 2013 and therefore remedies outlined in our letter to you dated September 26, 2013, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245499	A. Building B. Wing	10/28/2013

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0166** Reg. # **483.10(f)(2)** LSC	**10/22/2013**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	**10/22/2013**	ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	**10/22/2013**
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	**10/22/2013**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	**10/22/2013**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	**10/22/2013**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GN/KJ	11/08/2013	10160	10/28/2013
CMS RO				

Followup to Survey Completed on: 9/12/2013

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit
245499		**01 - THE LUTHERAN HOME CALEDONIA**	10/26/2013

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

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

(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0050	**10/24/2013**

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/KJ	11/08/2013	25822	10/26/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 9/9/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: E33Y
Facility ID: 00073

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245499**

2. STATE VENDOR OR MEDICAID NO. (L2) **190176100**

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

4. TYPE OF ACTION: **2** (L8)

1. Initial
2. Recertification
3. Termination
4. CHOW
5. Validation
6. Complaint
7. On-Site Visit
9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **07/01/2004**

6. DATE OF SURVEY **09/12/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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: (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Robin Lewis, HFE NE II 10/23/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 12/12/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **10/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

At the time of the standard survey completed September 12, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to bewidespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 5391

September 26, 2013

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

RE: Project Number S5499020

Dear Ms. Rauk:

On September 12, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

> **<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;**
>
> **<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904

Telephone: (507) 206-2731

Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 22, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 22, 2013 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by December 12, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may

still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 12, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117   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
	245499	A. BUILDING ______ B. WING ______	09/12/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verificatio	F 000		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to investigate and make prompt efforts to resolve a grievance for 1 of 1 resident (R4) who verbalized a concern and there was no documentation on the grievance. Findings include: R4's diagnoses included but were not limited to senile dementia and macular degeneration. R4's significant status change Minimum Data Set dated 7/3/13, identified R4 was cognitively intact. On 9/9/13, at 3:01 p.m. R4 was asked if staff, a resident or anyone else here abuse you and R4	F 166 10/23/13 SPN	To prevent a recurrence of this issue, staff will be re-educated on the Resident Rights and the facility practice for promptly resolving any complains or concerns (this process does include the resident's right to file a written grievance.) Because any given individual may feel a cause for complaint that may be impossible to identify beforehand, a plan to remind each resident of their rights will be instituted as well. Currently, residents are apprised of their rights upon admission and receive a booklet regarding these rights. The facility also posts information about resident rights in a public area;	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marian Rauk — TITLE: Administrator — (X6) DATE: 10.10.13

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.

OCT 14 2013
MN Dept of Health
Rochester

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245499	A. BUILDING ____ B. WING ____	09/12/2013

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

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F 166	Continued From page 1 indicated, "Yes." R4 stated they had a diagnosis of macular degeneration and one night resident was incontinent of bladder and the nurse came in the room and removed R4's night gown and wiped R4's eyes with the wet nightgown. R4 indicated the incident had happened to her a couple of weeks ago and R4 had reported the incident to the manager on duty. On 9/10/13, at 2:31 p.m. the social service director (SSD) indicated she was unaware of any concerns from R4. SSD indicated resident was just in the office within the past couple of weeks and had not said anything about any concerns. On 9/10/13, at 2:35 p.m. the interim director of nursing (DON) indicated R4 had made a couple of comments in the past about a wet night gown in the face. The DON stated R4 reported the staff was removing the night gown and it was soiled and had gone across R4's face. The DON stated she had talked with R4 and the staff, but had not documented the conversations. The DON indicated she had not felt the incident was abuse or reportable, so had not documented. On 9/11/13, at 2:10 p.m. SSD stated, "Grievances typically come to us with a verbal concern and we try and correct the issue." SSD stated the facility policy was related to written grievances, but SSD had not had any written grievances. SSD stated she had not offered "written grievances," but verified the information had been reviewed and given to residents and families upon admission in the admission packet. SSD verified R4 had been admitted 13 years ago and would probably not request or think to fill out a grievance form. SSD indicated if a resident came forward with a concern, "I would document any concerns and	F 166	however, to be sure that each resident is aware, these rights will be reviewed with each resident and family during Quarterly Care Conferences. Furthermore, the social worker will continue to do a periodic review of resident rights statements at the monthly Resident's Council meetings. With this continued practice, residents will receive an additional full review of all rights annually. The re-education of our staff will be completed by November 1, 2013. In order to monitor our performance, audits will be taken during care conferences until our next Quality Assurance and Improvement Committee meeting December 17, 2013 and March 2014 where the results of those audits will be reviewed to evaluate the need for any further staff education.	10-22-13

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F 166	Continued From page 2 would expect others to do as well." The Caledonia Care and Rehab Administration Grievances and Complaints policy dated 5/2006. The policy indicated Caledonia Care and Rehab wanted the experience of each resident in its various programs to be a positive one. Persons who had concerns about the services and care given them are encouraged to report them to the employee who was caring for them. The employee to whom the concerns were reported would, whenever possible, resolve these concerns. If the concerns were not resolved, the resident, the employee or anyone aware of the concerns, is to refer to the Procedure for General Grievances. A grievance or complaint must be in writing, contain the name and address of the person filing it, and briefly describe the complaint.	F 166		
F 226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the abuse prevention policy provided clear direction regarding immediate notification to the State agency (SA) for all allegations of mistreatment. This had the potential to affect all 50 residents in the facility. Findings include: The Vulnerable	F 226	On 9-11-13 the Vulnerable Adult Policy handbook was reviewed and the policy entitled "Reporting Maltreatment of Vulnerable Adults" was updated to clarify that reports will be made immediately to the Administrator and the Office of Health Facility Complaints (OHFC). All sentences containing the information "within 24 hours" were removed from the policy. On 9-13-13 the form used by the nursing staff entitled "Reporting Vulnerable Adults to the State" was also updated to read that the staff should report immediately to the Administrator and to the OHFC.	

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F 226	Continued From page 3 Adult/Maltreatment prevention plan & reporting policy lacked clear instruction to report allegations of abuse, neglect and mistreatment immediately to the other officials in accordance with State law through established procedures (this includes the office of health facility complaints-OHFC). The Reporting Maltreatment of vulnerable adults policy dated 9/2009, read, "Staff incidents that were reportable will be reported by the designated reporter within twenty-four hours to the Common Entry Point via telephone, and to the Office of Health Facility Complaints (OHFC) via the internet, or to one of the following agencies: a. Houston County Human Services Department (CEP) or (725-5811) b. Houston County Sheriff, or (725-3379) c. Office of Health Facilities Complaints, Minnesota Department of Health, Minneapolis, MN or (1-612-296-3730 or 1-612-297-2766) d. Licensing Division, Minnesota Department of Public Welfare, St. Paul, MN (1-612-296-3730 or 1-612-297-5562)" An undated posting at the nurse's station titled Reporting Vulnerable Adults to the State read, "The state requires us to report Vulnerable Adult incidents directly to them in addition to reporting to the common entry point. THESE REPORTS NEED TO BE MADE WITHIN 24 HOURS OF THE INCIDENT." On 9/11/13, at 2:14 p.m. social service director (SSD) indicated once an incident report was completed, information was gathered from the staff. If the resident was competent, would interview for more information and determine if reportable. SSD indicated if the incident was reportable; the SSD would then complete the	F 226	All residents were determined to have the potential to be affected by the policy, thus immediate correction of the policy took place on 9/11/13. The Vulnerable Adult Handbook will be reviewed by November 1, 2013 for accuracy and compliance with state and federal regulations. The handbook will be reviewed annually by the social worker. The social worker will monitor for state and federal changes with the Vulnerable Adult policies through DHS bulletins and Aging Services Monday Mailing updates, and update the Vulnerable Adult Policies as regulations require.	10/22/13

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F 226	Continued From page 4 online report to OHFC and also to Houston County via fax immediately within 24 hours. SSD verified the policy could be interpreted as being up to 24 hours you have to notify OHFC even though immediately was also present in the same sentence. On 9/12/13, at 8:25 a.m. the administrator verified the policy had not been updated to direct staff to immediately notify the SA and not up to the 24 hours as written in the current policy.	F 226		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the residents' environment was free of foul odors for 4 of 10 residents (R1, R24, R38 and R50) who had R1 and R50 (room 314) in a separate bedroom then R24 and R38 (room 316) but both rooms shared the same bathroom facility. Findings include: On 9/10/13, at 8:18 a.m. shared bathroom between rooms 314 and 316 had strong urine odors present in the bathroom that spread into both rooms 314 and 316. During the environment tour on 9/12/13, at 8:30 a.m. the maintenance director and administrator verified the facility had been aware of strong urine odor in the shared bathroom for rooms 314 and	F 253	To prevent a recurrence of this issue, we will trial a new cleaning product and cleaning equipment to better clean in cracks and spots that are difficult to reach with ordinary cleaning tools. Additionally, staff will be reminded, at an all staff meeting, to store products in the "housekeeping" room so they are easily accessible which encourages initiation of standard cleaning practices when spills or incontinent episodes should occur.	

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F 253	Continued From page 5 316 as they accompanied this surveyor on the tour. When standing in the bathroom and outside the doors to the bathroom there was strong urine odors. The maintenance director stated at the time that it would be the housekeeping department's responsibility to handle the strong urine odor in the bathroom. The administrator then stated the bathroom was to be cleaned daily with peroxide by the facilities universal workers (universal workers are staff who work in the roll as nursing assistants, cleaning, laundry, etc.) The administrator verified cleaning the bathroom with peroxide once a day apparently had not eliminated the strong urine odor in the resident's shared bathroom. On 9/12/13, at 9:31 a.m. a nursing assistant (NA)-A who also was considered a universal worker stated the day shift staff were responsible for cleaning the resident rooms and bathrooms on their assigned wings. NA-A stated she would have used the cleaning supplies that were used for all resident rooms to clean the shared bathroom especially for bathroom 314/316 and was unaware they were to use peroxide as a cleaner odor eliminator on a daily basis. During an observation at this time, NA-A verified the bathroom smelled like "Old urine" and stated this was how the bathroom normally smelled. On 9/12/13, at 9:39 a.m. NA-B stated the nursing assistants were responsible for cleaning resident rooms and bathrooms during their day shift. NA-B stated there was nothing different in the cleaning regimen for the shared bathroom for rooms 314/316 and stated it would be cleaned like all of the other bathrooms on the hallways. When asked specifically if peroxide was to be used when cleaning the shared bathroom, NA-B	F 253	The product trial will commence upon receipt of the equipment from the supplier and staff training by that supplier. Reminders regarding use and storage of current products will be completed by November 1, 2013. Following the commencement of the product trial, audits of room 314 and 316 and any other rooms with frequent odor problems related to urine spills will be initiated. The audits will be done daily for two weeks, then room audits of these rooms (if they remain applicable [with same residents] OR a random room audit should the resident situation change) will be completed monthly for three months and the product evaluated for effectiveness. Random room audits will then be accomplished quarterly for the remainder of the year and then evaluated by November of 2014 for any further training needs or product changes.	10/22/13

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FORM APPROVED
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F 253	Continued From page 6 responded, "I just thought of that. Once a week we are supposed to clean the bathroom with peroxide and I believe it is on Saturdays." NA-B stated she received these instruction through an electronic communication through the facility computer system and verified this was the only communication she had received regarding using peroxide to clean the bathroom. NA-B stated when new staff start it becomes the responsibility of the staff members training them to remember to teach them how to clean the shared bathroom with peroxide on Saturdays as there are no written instructions to staff to clean the shared bathroom 314/316 with peroxide. During an observation at this time, NA-B verified bathroom smelled like "strong" urine. On 9/12/13, at 10:15 a.m. the administrator verified there had been a concern with a strong urine odor in the shared bathroom of 314/316 for over a year. The administrator verified the internal communication to staff regarding cleaning the bathroom once a week on Saturdays with peroxide was completed on 8/9/12 via the computer. The administrator shared the facility is now using Hillyard to order chemicals for cleaning and the facility would be looking into available cleaning chemicals to use for rooms that have a strong urine odor. Review of internal communication dated 8/9/12 instructed staff to, "Continue with the peroxide for the floors in the bathrooms to keep odors to a minimum." The rooms identified included the shared bathroom of 314 and 316. "The peroxide is to be used in the bathrooms on Saturday of each week and is in the housekeeping rooms. The mentioned rooms may need it more often."	F 253		

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F 280	Continued From page 7	F 280		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan to implement fall interventions for 1 of 3 residents (R51) reviewed for falls. Findings include: R51 had had 13 falls occur between 7/3/13 and 9/6/13 and R51 ' s comprehensive care plan had not been revised to reflect the new preventative measures to be implemented for fall prevention. R51 was admitted on 6/24/13, with diagnosis	F 280	Any time a resident falls, nurses are to assess the need for new measures for fall prevention. In order to improve documentation and communication of new interventions, our current electronic record will be set to provide a reminder to the writer of any incident to go directly to the care plan. From within the care plan documentation area, a reminder exists to initiate an internal communication accessible by all pertinent employees. There is also another reminder to add or update content that will flow to the CNA daily assignment sheets. The facility Safety Committee will provide incident follow up with further care plan review. The Safety Committee will also discuss and consider changes to the facility environment, staffing etc. as may be brought to their attention by any other staff or resident.	

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F 280	Continued From page 8 which included, but not limited to Parkinson's disease. R51's admission Minimum Data Set dated 7/9/13, identified the resident as severely cognitively impaired. The resident required extensive assistance of two plus staff with transfers, ambulation and toileting. R51 had fallen in the last two to six months prior to admission. The care area assessment summary revealed R51 had falls in the past six months prior to admission and one fall since admission. R51 had not routinely used the call light and was frequently reoriented to call light. Bed alarm had been placed for safety. On 9/11/13, at 10:12 a.m. R51 was observed sitting in a recliner in their room with the recliner remote sitting on right arm rest of the chair within R51's reach. Review of R51's fall incident on 7/28/13, indicated the preventative measure to prevent further falls was to remove recliner remote from resident reach to prevent further incidents. However this preventative measure had not been care planned. R51's care plan dated 7/20/13, identified R51 had potential for injury related to decline in cognitive status, Parkinson's, unsteady gait, incontinence, and decline in functional status. R51 had a history of falls and use of psychotropic medications. Interventions in place included assess need for further interventions such as a change to toileting schedule, activities, positioning or snacks if falls had a regular pattern, place a bed alarm while in bed at night to alert staff of self-transfers, low bed to decrease risk of injury from falls, notify wife and physician if falls occur and perform a fall	F 280	Staff will receive reminders and additional training related to the need to review and update care plans in the electronic medical record at the time of any incident or significant change in condition. This review will be provided at an all staff meeting to be completed by November 1, 2013. The Safety Committee will monitor any incidents, documentation and communication at each meeting held every four to six weeks throughout the year.	10/22/13 SPN

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F 280	Continued From page 9 investigation within 24 hours of fall to try and find reasoning for incident if restless and hard to settle at night please call wife per request as she has offered to come in and sit with resident, assist to the toilet every two to three hours per schedule and on demand, ensure call light was within reach at all times while in room although R51 rarely used it do to cognitive deficit, reorient as needed and educate/remind to use call light ensure room was safe and remained a clutter free environment, assist with one to two staff gait belt and walker for all transfers and ambulation, position in recliner if restless in bed, most of recent falls had occurred in early morning hours so assist to toilet and then to recliner and put TV on for distraction per wife's recommendations to prevent early morning falls and bed alarm on my bed. However, the care plan had not addressed keeping the recliner remote out of resident reach. On 9/12/13, at 8:22 a.m. the administrator verified the process for fall incidents as follows: An incident report would be completed, within 24 hours a nurse completes a follow up and if an intervention was needed immediately, the staff on duty had the authority to do that. If the nursing staff decided the preventative measure was an intervention would than go on the internal communication by the next day nurse. The Administrator expected the preventative measure interventions to be reviewed with the 24 hour follow-up. If the preventative measure intervention had been determined appropriate, it would be part of the follow-up note whether to continue with the preventative measure and then the measure was to be care planned. On 9/12/13, at 8:38 a.m. the interim director of nursing (DON) indicated the preventative	F 280		

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F 280	Continued From page 10 measures for residents had been communicated through the internal communication via the computer internal email and would also be documented on the care plan. The policy for Formulation of Resident Care Plans dated 8/2010, indicated each resident had a care plan present on the chart that provided information for all members of the interdisciplinary care team regarding guidelines for individualized care.	F 280		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident specific fall interventions were implemented according to the resident's comprehensive falls assessment for 1 of 3 residents (R51) identified as having a history of falls and at risk for falls. Findings include: R51 had 13 falls from 7/3/13 to 9/6/13 and even though the facility completed the falls assessment and recommended an intervention the intervention had not been care planned and the resident was put at risk of falls again using the same assessed unsafe chair	F 323	R51 had his care plan updated to indicate that his remote for his lift chair will be placed in the pocket of his recliner. This was placed on the nursing assistant flow sheet, also. The incident report form was reviewed and there was a "go to" word placed on the report form to not allow the nursing staff to leave the report area without proceeding to the care plan to place the appropriate information/intervention on the care plan. Then a care plan "go to" word was place to document follow through on the Nursing Assistant	

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F 323	Continued From page 11 remote. R51 was admitted to the facility on 6/24/13, with diagnosis of Parkinson's disease. The admission Minimum Data Set (MDS) dated 7/9/13, identified R51 had severe cognitive impairment and required extensive assistance with transfers, toileting and ambulation. The care area assessment summary revealed R51 had falls in the past six months prior to admission and one fall since admission. R51 had not routinely used the call light and was frequently reoriented to call light. A bed alarm had been placed for safety. The fall risk assessment dated 6/24/13; identified R51 had a history of falls, balance deficit, visual deficit, on diuretics/laxatives and required an assistive device for ambulation and/or transfers. R51's care plan dated 7/20/13, identified R51 had potential for injury related to decline in cognitive status, Parkinson's, unsteady gait, incontinence, and decline in functional status. R51 had a history of falls and use of psychotropic medications. The care plan interventions included pertinent interventions for fall preventions such as identification R51 rarely used the call light due to cognitive impairment, direction to remind R51 to use the call light, to keep the call light in reach. However, R51 ' s care plan did not address keeping the recliner remote out of R51's reach. Review of R51 ' s incident reports revealed the resident had a fall and it was assessed and appropriate interventions developed except for the following two falls: On 7/22/13, at 3:35 a.m. R51 was calling for help and found sitting on the floor in front of lift recliner chair in its highest position. R51's finger still on	F 323	Assignment Sheet. Education will be provided to the nursing staff on the changes implemented to the process of reporting and follow through of care plan and assignment sheet. The DON/designee will audit the incident/accident reports to assure that the process is maintained for follow through onto the care plan and assignment sheet. The audits will be reported at the QAA meeting to the interdisciplinary team. These audits will be done weekly for one month and then quarterly for one year.	10/22/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245499	A. BUILDING ______ B. WING ______	09/12/2013

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

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F 323	Continued From page 12	F 323		

the raise chair button. Preventative measure was to remind to use call light for transfers.

On 7/28/13, at 7:00 p.m. R51 was found in bedroom on floor on left side of body next to recliner chair, previously resident put recliner in high position independently and slipped out to the floor. Preventative measure put in place were to ensure recliner remote not in resident reach. On 9/11/13, at 1:33 p.m. RN-A indicated should had probably been implemented with the first fall out of the recliner chair.

Even though the recommendation to remove the recliner remote from R51 ' s access it had not been documented in R51 ' s care plan which lead to the staff giving the remote to R51 again.

On 9/11/13, at 10:15 a.m. a nursing assistant (NA)-C and registered nurse (RN)-B had been observed to transfer R51 to the recliner in room. R51's feet were elevated and staff left recliner remote sitting on the right chair arm within reach of the resident.

On 9/11/13, at 10:35 a.m. RN-B verified there was no nursing assistant care sheet/care plan available for nursing assistants for R51.

On 9/11/13, at 10:38 a.m. the licensed practical nurse (LPN)-B confirmed they usually worked the overnight shift. LPN-B identified the following preventative measures R51 currently had a tether alarm in chair and when in bed, the bed is all the way to the floor sensor mat in bed and mat next to bed, and call light in reach. The only prevention was tether alarm in recliner and more frequent checks just doing more in the range of 15 minute

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F 323	Continued From page 13 checks. LPN-B stated if they were at the desk, LPN-B would sit at the side so LPN-B could monitor R51 if he became restless. LPN-B stated R51 would try to reposition or toilet or get R51 into bed or wheelchair. LPN-B also listed to take R51 out of his room and provide a 1 to 1 with staff. LPN-B was brought into R51's room and LPN-B verified the chair remote should have been placed down in the side pocket out of R51 ' s reach. LPN-B indicated they communicate changes in resident cares via email and verbally from staff to staff. On 9/11/13, at 11:41 a.m. NA-C indicated fall interventions for R51 had been alarm in the bed, call light within reach and would also follow the assignment sheet. NA-C also indicated in the morning R51 can get a little restless so they try and stay in the immediate area of R51's room. NA-C indicated resident usually gets up around 7:00 a.m. to 7:30 a.m. NA-C reviewed CAN (certified nursing assistant) a.m. assignment sheet dated 9/11/13, and indicated that was what NA-C had followed. Again the removal of the recliner remote had not been included on this sheet. On 9/11/13, at 1:51 p.m. RN-A identified new interventions were communicated via daily nursing report in regards to changes in resident cares. RN-A indicated the nurse will complete the form and the direct staff would be updated via a note in communication book. RN-A indicated they thought the recliner remote removal would have been a good intervention. RN-A continued to say the process for fall procedure was the incident report was completed, the fall follow-up was done the next day and look at scenario and typically put on the calendar for any LPN or RN to follow up.	F 323		

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F 323	Continued From page 14	F 323		

RN-A indicated if residents were falling a lot they would look more closely at the assessments and more in depth with the falls. RN-A indicated with this resident functional safety risk assessment would be completed as R51 was at high risk for falls.

On 9/12/13, at 8:03 a.m. NA-D indicated R51 was the first resident NA-D got ready in the morning. NA-D verified the shift started around 7:00 a.m. NA-D indicated R51 had a bed alarm, tether alarm, mat next to bed, on occasion used EZ stand and two people with gait belt. NA-D said if resident was crawling out of bed, staff was to get R51 up out of bed. NA-D indicated when R51 was in recliner, staff was to put the tether alarm on and put R51's feet up. When asked if NA-D was aware of any intervention about removing the remote for the recliner, NA-D stated R51 should "probably not have the remote."

On 9/12/13, at 8:38 a.m. interim director of nursing (DON) indicated there were no timing and patterns trends identified with R51's falls when asked if they look at possible root cause analysis leading to the fall/s. DON indicated we do try to switch up R51's routine if R51 was restless staff would get him out of bed, put resident in the recliner and see if restlessness was related to comfort. DON indicated the process of when a resident falls was to complete an incident report, notify physician and family within 24 hours, a LPN or RN would complete a fall follow-up and try to put in interventions. The DON indicated we also discuss in morning meetings when department heads meet and discuss falls that have occurred. DON indicated R51 ' s alarms were in place and mat had been on the floor. On asking about the

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F 323	Continued From page 15 recliner remote removal recommendation after R51 had fallen the DON said this intervention should have been documented on the care plan. The DON also verified R51 should have been gotten out of bed when alarm sounded this morning as this is one of the care plan interventions to prevent falls.	F 323		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 431	A policy for the removal of Fentanyl/Duragesic transdermal patch removal, and disposition will be written. This policy will include information on correct removal from the resident and affixation of the used patch to a disposal/documentation slip which will be signed and dated by the person removing the patch. This slip with patch attached will then be locked with all other scheduled/controlled prescription drugs awaiting destruction and disposal within the facility. Documentation of removal of the patch within the medication administration record will provide a second check of personnel handling this type of medication. The	

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F 431	Continued From page 16 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation review, the facility failed to document destruction of the controlled substance of fentanyl patches (a narcotic used for moderate to severe pain) and the facility did not follow the current recommendations for disposal of medication versus use of an unsecured access garbage can. This practice could potentially encourage diversion of pain medications by staff, residents and/or visitors. Findings Include: The facility had not documented actual disposition of used fentanyl patches by two persons authorized to dispose of narcotic medications and the nursing staff were currently using an unsecured trash container to dispose of the narcotic medication which allowed anyone free access to the narcotic medication until it is buried in the landfill or incinerated. Food and Drug Agency warn Fentanyl patches even when removed from resident use still contain useable amounts of the narcotic medication in the patch/s. On 9/12/13, at 8:41 a.m. the licensed practical nurse (LPN)-A informed surveyor the used fentanyl patches were thrown away in the trash. LPN-A stated when used fentanyl patches are removed from the resident/s, we fold the patch in half onto itself, throw the patch into the garbage in the residents room, take the garbage out with you when you leave the room and throw the bag	F 431	destruction of scheduled/controlled substances will occur approximately monthly in the presence of the facility's consulting pharmacist. This policy will afford safe and secure storage as well as allowing inventory of staff handling these pharmaceuticals. Nursing staff will be provided the policy and receive education on the new policy. The policy was written and received approval from the medical director on September 24, 2013. Staff education on the policy will occur on October 24th and the policy will then be instituted following that educational meeting. The automated "exception report" within the electronic medical record will provide a reminder to document and may be accessed at any time to determine compliance.	

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F 431	Continued From page 17 of garbage removed from the residents room into the big garbage can in the utility room. LPN-A verified at the time the nurse removing the patch is the only nurse present when the fentanyl patch is thrown away (two nurses are not present) and verified there was no log of destruction for used fentanyl patches. On 9/12/13, at 9:31 a.m. the interim director of nursing stated, "We do not log destruction of used fentanyl patches." On 9/12/13, at 11:15 a.m. the facility consultant pharmacist stated he would expect staff to dispose of used fentanyl patches by wetting a paper towel, pat fentanyl patch on the wet paper towel and flush the fentanyl patch down the toilet or fold fentanyl patch on itself and place into a sharps container for incineration. At 11:21 a.m. facility pharmacist consultant stated he would expect one nurse and a pharmacist to log destruction of used fentanyl patches. The CALEDONIA CARE AND REHAB NURSING POLICY DISPOSITION OF CONTROLLED SUBSTANCES IN NURSING HOME dated 7/2010, read "Policy: Caledonia Care & Rehab will dispose of controlled substances as set up by the bureau of Narcotics and Dangerous Drugs (BNDD). The Bureau of Narcotics and Dangerous Drugs has allowed an optional method for disposition of controlled substances in Minnesota nursing homes. Drugs Schedule II-V may now either be inventoried or surrendered to the Chicago, Il Regional Office of BNDD or they may be destroyed in accordance with the following conditions: Procedures: 1. All controlled substances will be destroyed in the presence of a licensed staff or the consulting/supplying	F 431	On-going monitoring will occur at the time of medication destruction when the charge nurse (or designee) working with the consulting pharmacist will determine if there are any missing patches.	10/22/13 AFN

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F 431	Continued From page 18	F 431		

pharmacist to the nursing home. 2. An inventory of all controlled substances destroyed and the date and method of destruction must be submitted to Minnesota Board of Pharmacy upon destruction."

The current Food and Drug Administration (FDA) updated April 14, 2011. Guidelines for Drug Disposal indicated, FDA worked with the White House Office of National Drug Control Policy (ONDCP) to develop the first consumer guidance for proper disposal of prescription drugs. Issued by ONDCP in February 2007 and updated in October 2009, the federal guidelines are summarized here:

Follow any specific disposal instructions on the drug label or patient information that accompanies the medication. Do not flush prescription drugs down the toilet unless this information specifically instructs you to do so.

Take advantage of community drug take-back programs that allow the public to bring unused drugs to a central location for proper disposal. Call your city or county government's household trash and recycling service (see blue pages in phone book) to see if a take-back program is available in your community. The Drug Enforcement Administration, working with state and local law enforcement agencies, is sponsoring National Prescription Drug Take Back Days throughout the United States.

If no instructions are given on the drug label and no take-back program is available in your area, take them out of their original containers and mix them with an undesirable substance, such as used coffee grounds or kitty litter - to make the medication less appealing and unrecognizable - then put them in a sealable bag, empty can, or other container to prevent the

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F 431	Continued From page 19 medication from leaking or breaking out of a garbage bag.	F 431		

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

F5499022

PRINTED: 09/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245499	A. BUILDING 01 - THE LUTHERAN HOME CALEDONIA B. WING	09/09/2013

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Caledonia Care and Rehab was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	POC ok TB 10-23-13 RECEIVED OCT 14 2013 MN DEPT OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Dc: 10.22.2013

Exit: 9.12.2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marian Rauk
TITLE: Administrator
(X6) DATE: 10.10.13

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 By email to: Barbara.Lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Caledonia Care and Rehab is a 1-story building. The building was constructed at 3 different times. The original building was constructed in 1961 and was determined to be of Type II(000)construction, with a full basement. In 1971, addition was constructed and was determined to be of Type II(000) construction, with no basement. In 1975, addition was constructed and was determined to be of Type II(000) construction, with no basement. Because the original building and the 2 additions are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered as of 06/30/2013. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 50 beds and had a census of 50 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 50 residents. Findings include: On facility tour between 1:00 PM and 3:30 PM on 09/09/2013, the review of the fire drills reports for September 2012 to August 2013. The 2012/2013 - 3rd quarter - evening shift drill was missed.	K 050	The fire drill for the evening shift that was missed was done on 9.11.2013. Audit sheets were completed to assure that this practice does not occur again on 10.9.2013. Audits will be done by members of the Safety Committee and reported back to the Safety Committee on a four to six week basis. A Safety Committee member will then report to the QAA Committee to assure follow through has occurred on a quarterly basis. Education will occur at the October 24, 2013 all staff meeting.	

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K 050	Continued From page 3 This deficient practice was confirmed by the facility Maintenance Director (RK) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 050		