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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: E9FT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00649

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245383**
2.STATE VENDOR OR MEDICAID NO.
(L2) **633442000**

3. NAME AND ADDRESS OF FACILITY
(L3) **OWATONNA CARE CENTER**
(L4) **201 SOUTHWEST 18TH STREET**
(L5) **OWATONNA, MN** (L6) **55060**

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) **01/01/2011**

6. DATE OF SURVEY **12/08/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **03** (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)
12/31

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

12.Total Facility Beds **55** (L18)

13.Total Certified Beds **55** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	43	12		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 12/17/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/18/2014 (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
12/01/1986
(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.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/17/2014
(L33)

DETERMINATION APPROVAL

CMS Certification Number (CCN): 245383

December 18, 2014

Ms. Shelley Solberg, Administrator
Owatonna Care Center
201 Southwest 18th Street
Owatonna, Minnesota 55060

Dear Ms. Solberg:

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 December 3, 2014 the above facility is certified for:

12	Skilled Nursing Facility Beds
43	Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 55 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, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

December 17, 2014

Ms. Shelley Solberg, Administrator
Owatonna Care Center
201 Southwest 18th Street
Owatonna, Minnesota 55060

RE: Project Number S5383027

Dear Ms. Solberg:

On November 6, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 24, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 8, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 12, 2014 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 October 24, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 3, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 24, 2014, effective December 3, 2014 and therefore remedies outlined in our letter to you dated November 6, 2014, 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,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245383	01 - MAIN BUILDING 01	12/12/2014

Name of Facility	Street Address, City, State, Zip Code
OWATONNA CARE CENTER	201 SOUTHWEST 18TH STREET OWATONNA, MN 55060

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 Reg. # NFPA 101 LSC K0050	12/03/2014	ID Prefix Reg. # NFPA 101 LSC K0069	12/03/2014	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		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	PS/KFD	12/17/2014	25822	12/12/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
10/20/2014	

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245383	02 - 1992 ADDITION	12/12/2014

Name of Facility	Street Address, City, State, Zip Code
OWATONNA CARE CENTER	201 SOUTHWEST 18TH STREET OWATONNA, MN 55060

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 Reg. # NFPA 101 LSC K0050	12/03/2014	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		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/kfd	Date: 12/17/2014	Signature of Surveyor: 25822	Date: 12/12/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 10/20/2014		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: E9FT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00649

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245383**

2.STATE VENDOR OR MEDICAID NO. (L2) **633442000**

3. NAME AND ADDRESS OF FACILITY
(L3) **OWATONNA CARE CENTER**
(L4) **201 SOUTHWEST 18TH STREET**
(L5) **OWATONNA, MN** (L6) **55060**

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) **01/01/2011**

6. DATE OF SURVEY **10/24/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 03 (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) **12/31**

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

12.Total Facility Beds **55** (L18)

13.Total Certified Beds **55** (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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	43	12		
(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 :
Jennifer Lageson, HFE NE II 12/02/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/17/2014 (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 **12/01/1986** (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. **00320** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3055 0127

November 6, 2014

Ms. Shelley Solberg, Administrator
Owatonna Care Center
201 Southwest 18th Street
Owatonna, Minnesota 55060

RE: Project Number S5383027

Dear Ms. Solberg:

On October 24, 2014, 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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
gary.nederhoff@state.mn.us
Telephone: (507) 206-2731
Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 3, 2014, 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 December 3, 2014 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 January 24, 2015 (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 April 24, 2015 (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 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245383	A. BUILDING 4 B. WING	10/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWATONNA CARE CENTER	201 SOUTHWEST 18TH STREET OWATONNA, MN 55060

(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 verification.	F 000	This plan of correction is submitted as required under Federal and State laws. The submission of this Plan of correction does not constitute an admission on the part of Owatonna Care Center as to the accuracy of the surveyors' findings or the conclusions drawn there from. The Plan of Correction also does not constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Facility's policies and procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on this basis. The Facility submits this plan of correction with the intention that it be inadmissible by any third party against the Facility or any employee, agent, officer, director, attorney, or shareholder of the Facility or affiliated companies.	
F 165 SS=D	483.10(f)(1) RIGHT TO VOICE GRIEVANCES WITHOUT REPRISAL A resident has a right to voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to respond to call light grievances for 1 of 9 residents (R24) interviewed who reported lack of call light response to the facility. This had the potential to affect all 35 residents in the facility. Findings include: During interview 10/21/14, at 9:53 a.m., R24 stated they had to wait over one hour for the bedpan at night, between 2:00 a.m. to 3:00 a.m., and then it took up to 25 minutes to get off the bedpan. R24 stated they had to wait in the day	F 165 12-2-14 GPN		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shelley Sellers — TITLE: Administrator — (X6) DATE: 11/21/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245383	A. BUILDING _____ B. WING _____	10/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWATONNA CARE CENTER	201 SOUTHWEST 18TH STREET OWATONNA, MN 55060

(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 165	Continued From page 1 time also for call light to be answered timely. During interview on 10/24/14, at 9:00 a.m., R24 stated they had reported to a nurse the long waits for call lights to be answered especially during the night. R24 was admitted to the facility 9/23/14, with diagnosis that included congestive heart failure according to the admission Minimum Data Set (MDS) dated 9/30/14, and diagnosis of fractured spine according to resident care plan report dated 10/12/14. The facility identified R24 on the admission MDS, an assessment dated 9/30/14, to have cognition intact and required extensive assist of one staff for activities of daily living. Observations of R24 ' s call light was turned on for help on 10/22/14, at 12:19 p.m. at 12:20 p.m., housekeeper (HSK)-A near R24's room, 12:27 p.m., maintenance staff and nursing assistant in hall across from R24's room, 12:28 p.m., same maintenance, nursing assistant, and HSK-A in hall near R24's room, 12:31 p.m., HSK-A in hall near R24's room, 12:32 p.m. licensed practical nurse (LPN)-C stood at the 300 wing nurses desk within view of call light, 12:35 p.m., same staff on 300 wing, 12:37 p.m., laundry person to 300 wing and at 12:38 p.m., call light was answered by office staff. During interview on 10/23/14, at 6:30 a.m., registered nurse (RN)-A stated from 3:00 a.m., to 6:30 a.m., the night shift had one nursing assistant for the whole facility. RN-A stated one resident required continuous observation due to restlessness. RN-A stated call lights were not	F 165	F165 1. Resident #24 grievance has been resolved. 2. Review of the last 30 days of grievances has been completed with concerns being addressed if any. 3. Staff will be educated on 12/02/2014 on the policy for grievances. 4. Administrator or designee will audit grievances weekly to ensure issues resolved. 5. Any concerns identified will be addressed at the facility's Quality Assurance meeting. 6. Compliance date: 12/3/2014	12/3/14

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	245383	A. BUILDING _____ B. WING _____	10/24/2014

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F 165	Continued From page 2 answered for a long time during the times the resident needed continuous observation. During interview on 10/23/14, at 6:50 a.m., nursing assistant (NA)-D stated had worked part of that night as the only nursing assistant. NA-D stated they were not able to answer call lights quickly due to watching the one resident who needed continuous observation when they were up at night. During interview on 10/23/14, at 7:01 a.m., NA-A stated they were aware R24's call light was on over one hour during a recent night shift. NA-A stated R24 had been incontinent due to the long wait. Document review of facility answering call light policy dated 10/2010, read, " #8. Answer the resident's call as soon as possible." During interview on 10/24/14, at 10:05 a.m., director of nursing stated she was aware of complaints of long waits for call lights to be answered. Director of nursing stated she had educated staff on answering call lights timely. She stated she expected all floor nurses, nursing assistants, trained medical assistants, and all other staff to answer call lights.	F 165		
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	F 242		

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	245383	A. BUILDING _____ B. WING _____	10/24/2014

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F 242	Continued From page 3 are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide 1 of 2 residents (R24) reviewed for choices, the choice of participating in an activity programs instead of staff making the resident attend physical therapy. Findings include: R24 was admitted to the facility 9/23/14, with diagnosis that included congestive heart failure according to the admission Minimum Data Set (MDS) dated 9/30/14, and diagnosis of fractured spine according to resident care plan report dated 10/12/14. The facility identified R24 on the admission MDS, an assessment dated 9/30/14, to have cognition intact and required extensive assist of one staff for activities of daily living. Document review of resident care plan report dated 10/12/14, directed staff to encourage R24 to attend activities and to assist R24 to and from activity areas. During interview on 10/21/14, 9:50 a.m., R24 was observed in bed. At that time, an activity staff opened room door and stated there would be an activity at 10:00 a.m. R24 stated she often wanted to attend activities but physical therapy told her she needed therapy two times a day so she had to go to therapy. During observation on 10/21/14, at 10:20 a.m., a	F 242	F242 1. Resident #24 has been offered a schedule for therapy. 2. All residents on therapy case load have been asked preference of a schedule for therapy to be able to maintain a time for leisure activities and therapy. 3. The COTA was educated on resident choices 11/4/2014 and all staff will be educated on 12/02/2014 on choices. 4. Administrator or designee will audit random residents on therapy case load weekly to ensure issues resolved. Weekly audits completed per MDS schedule to ensure resident choice. 5. Any concerns identified will be addressed at the facility's Quality Assurance meeting. 6. Compliance date: 12/3/2014	12/3/14

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F 242	Continued From page 4 nursing assistant (NA)-C pushed R24 in the wheelchair to the main dining room where an activity program was in progress. Observation at that time revealed that before NA-C reached the table with R24, a physical therapy (PT)-D arrived, took the wheelchair from NA-C and pushed R24 down the hall to physical therapy. Observations while pushed down the hallway revealed R24 told PT-D she wanted to attend the activity program. PT-D replied to R24 that she needed to go to physical therapy because she received physical therapy two times a day and each time it was for 1.5 hours. PT-D stated R24 could go to activities later. During interview on 10/23/14, at 1:10 p.m., social services (SS)-A stated she expected physical therapy to allow R24 the choice of activities or physical therapy. Document review of facility Quality of Life-Dignity policy dated 10/2009, read, " 5. Residents shall be assisted in attending the activities of their choice, including activities outside the facility." During interview on 10/23/14, 1:20 p.m., physical therapy aide (PTA)-C and physical therapist (PT)-E they both stated if physical therapy could accommodate they would give R24 the choice of physical therapy or activities. PTA-C stated she was aware of the incident when R24 was not allowed to attend the activity program.	F 242		
F 279 SS=E	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.	F 279		

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	245383	A. BUILDING _____ B. WING _____	10/24/2014

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F 279	Continued From page 5 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 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 interview and document review, the facility failed to develop a comprehensive care plan related to care and services for 3 of 3 residents (R17, R31 and R21) with R17 lacking pain and dialysis interventions; R31 lacked nutritional needs; R21 lacked range of motion and splint therapy for contractures. Findings include: Lacked dialysis information: R17's Admission Face Sheet indicated R17 was admitted on 10/10/2013 with diagnoses which included diabetes, hypertension, renal dialysis needs and chronic obstructive pulmonary disease. R17 had a fistula in the right upper arm which was accessed for dialysis three times per	F 279	F279 1. R17, R21, R31 care plans have all been reviewed and updated as needed to reflect care provided. 2. All care plans have been reviewed related to pain, nutrition, and dialysis. 3. Care plan nurse, Dietitian, and SS Director have been educated regarding F279 updating care planning to ensure timely updating to reflect care. 4. IDT team will review care plans quarterly, annually and with significant change. 5. Any concerns identified will be addressed at the facility's Quality Assurance meeting. 6. Compliance date: 12/3/2014	12/3/14

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	245383	A. BUILDING _____ B. WING _____	10/24/2014

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F 279	Continued From page 6 week. R17's quarterly Minimum Data Set (MDS) dated 10/01/14 identified cognitive status as alert and oriented and required extensive assistance of one staff for ADL's except for eating and did not ambulate. R17's care plan dated 7/23/2014 was reviewed. It did not address R17's dialysis treatments three times a week, location of fistula site, monitoring and identification of the fistula site, dialysis protocols and emergency protocols. On 10/24/2014 at 12 noon, the director of nursing (DON) verified interventions regarding dialysis treatment and emergency procedures were not addressed on R17's care plan. Lacked pain control interventions: R17's Admission Face Sheet indicated R17 was admitted on 10/10/2013 with diagnoses which included diabetes, hypertension, end stage renal disease and chronic obstructive pulmonary disease. R17's physician orders dated 10/21/2014 were reviewed and revealed the resident was on the following pain medication: Hydromophone HCL (Opioid narcotic) 2 mg 1-2 tablets as needed (prn) every 4 hours (order date 10/19/2014); Acetaminophen ES (pain medication) 500 mg 2 tablets prn every 6 hours; Lidoderm patch (numbing medication to control pain) daily; and Dilaudid (narcotic pain medication) 2 mg 1-2 oral prn every 4 hours. Pain assessment dated 7/1/2014 identified pain	F 279		

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F 279	Continued From page 7 from a wound, back pain, and leg pain (fracture.) R17's care plan dated 7/23/2014, was reviewed and did not address the resident's pain signs and symptoms and none-pharmacological interventions. . On 10/24/2014 at 12:20 p.m., the director of nursing (DON) was interviewed. She verified R17's pain interventions should be addressed because R17 had a lot of pain to control. Lack of nurtritional interventions: R31's Admission Face Sheet indicated R31 was admitted on 7/16/2010 with diagnoses which included: malignant neoplasm cerebellum, dysphagia (difficulty swallowing), anxiety state and malignant neoplasm of the kidney. A dietary assessment dated 5/7/2014 identified the resident was 66 inches tall and current weight at 113 lbs. The basal metabolic index (BMI) was identified as 19.2 which is less than the normal at 22. The resident was not on nutritional supplements. R31's care plan dated 5/7/2014 revealed R31 did not have nutritional needs addressed or interventions developed to prevent further weight loss. On 10/24/2014 at 12 noon, the director of nursing (DON) stated the care plan should address nutrition for R31 but it didn't. Lack of range of motion services: R21's quarterly Minimum Data Set (MDS) dated 8/12/14 included diagnoses of depression and	F 279		

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	245383	A. BUILDING _____ B. WING _____	10/24/2014

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F 279	Continued From page 8 anxiety, indicated moderate cognitive impairment and did not reject cares. On 3/17/14 Occupational Therapy made the following recommendation. Please perform passive range of motion (PROM) and stretch to left finger and hands. Resident has also been educated self-range of motion (ROM) but need reminders. Apply small tube splint to left hand after ROM as tolerated. R21's care guide and comprehensive care plan were reviewed and did not address ROM services or splint recommendation or contracture of pinky finger on left hand. The last care plan review was completed on 8/20/14. On 10/24/14 at 9:43 a.m. the director of nursing (DON) stated the recommendation made by occupational therapy for R21 to have PROM and to apply a small tube splint to left hand after ROM as tolerated was not implemented by nursing. The DON stated when the recommendation was made by therapy the clinical manager should have updated the care guides and care plan to notify staff of the new program to provide for R21. On 10/24/14 at 11:38 a.m. the administrator stated she expected staff would have followed through on the floor with the recommendations made by occupational therapy for PROM and to apply a small tube splint to left hand after ROM as tolerated for R21. The administrator stated she would have expected R21's left pinky contracture and the recommendations made by occupational therapy to be care planned. A policy was requested, but not provided by the facility.	F 279		

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F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement a therapy recommended splint and passive range of motion services (PROM) services for 1 of 1 resident (R21) with a contracture. Findings Include: R21's quarterly Minimum Data Set (MDS) dated 8/12/14 included diagnoses of depression and anxiety, indicated moderate cognitive impairment and did not reject cares. On 3/17/14 Occupational Therapy made the following recommendation. Please perform passive range of motion (PROM) and stretch to left finger and hands. Resident has also been educated self-range of motion (ROM) but need reminders. Apply small tube splint to left hand after ROM as tolerated. R21's care guide and comprehensive care plan were reviewed and did not address ROM, splint recommendation or contracture of pinky finger on left hand. The last care plan review was completed on 8/20/14.	F 318	F318 1. R21 has a PROM/splint program in place 2. All residents with contractures have been reviewed for appropriate interventions. Communication system has been revised between nursing and therapy. 3. Therapy and nursing have been educated on new communication process. 4. Director of Nursing and Therapy Manager or designees will audit random residents on case load weekly to ensure implementation. 5. Any concerns identified will be addressed at the facility's Quality Assurance meeting. 6. Compliance date: 12/3/2014	12/3/14

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	245383	A. BUILDING _____ B. WING _____	10/24/2014

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F 318	Continued From page 10 On 10/23/14 at 2:36 p.m. nursing assistant (NR)-A verified she was unaware of the recommendation from occupational therapy for R21 to have PROM and to apply a small tube splint to left hand after ROM as tolerated. On 10/24/14 at 11:19 a.m. nursing assistant (NR)-B verified she was unaware of the recommendation from occupational therapy for R21 to have PROM and to apply a small tube splint to left hand after ROM as tolerated. On 10/24/14 at 9:43 a.m. the director of nursing (DON) stated the recommendation made by occupational therapy for R21 to have PROM and to apply a small tube splint to left hand after ROM as tolerated was not implemented by nursing. The DON stated when the recommendation was made by therapy the clinical manager should have updated the care guides and care plan to notify staff of the new program to provide for R21.	F 318		
F 329 SS=D	On 10/24/14 at 11:38 a.m. the administrator stated she expected staff would have followed through on the floor with the recommendations made by occupational therapy for PROM and to apply a small tube splint to left hand after ROM as tolerated for R21. A policy was requested, but not provided by the facility. 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including	F 329		

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	245383	A. BUILDING _____ B. WING _____	10/24/2014

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F 329	Continued From page 11 duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure as needed (PRN) antianxiety medication had parameters for use, and non-pharmacological interventions were developed and implemented for 1 of 5 residents (R16) reviewed for psychotropic medications. Findings include: R16 was admitted on 7/24/2014 with diagnoses that included: diabetes, hypothyroidism, anxiety state, hypertension, and dementia according to the face sheet.	F 329	F329 1. R16 no longer resides at the facility. 2. Audit completed for all residents receiving PRN anti anxiety medication non pharmacological interventions were reviewed during the monthly psychotropic med meeting. 3. Nursing staff will be educated on 12/02/2014 on use and documentation of non-pharmacological interventions to be attempted prior to administration of medication. 4. Social Services/designee will audit random residents weekly with anti-anxiety medication to ensure non-pharmacological interventions are designated to be attempted prior to administration of medication. 5. Any concerns identified will be addressed at the facility's Quality Assurance meeting. 6. Compliance date: 12/3/2014	12/3/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 12 R16's Physician orders dated 10/21/2014 identified the resident was on Ativan (antianxiety medication) 0.5 mg up to three times a day as needed for agitation. R16's medication administration reports for 10/14 were reviewed. They revealed the resident was administered the as needed Ativan 2-3 times per day. R16's clinical notes reports dated 9/2/2014 through 10/23/2014 were reviewed and revealed the resident was administered Ativan 1-3 times a day and was effective. However, the notes did not identify why the Ativan was given or if non-pharmacological interventions were attempted prior to administering the medication and it they were affective. A Psychiatric consult dated 8/8/2014 was reviewed. It noted the resident had diagnoses of major depressive disorder, Parkinson's disease, generalized anxiety disorder, and dementia. Part of the plan identified Psychotherapy interventions that included: importance of exercise, frequency and duration, and supportive psychotherapy. R16's care plan dated 8/3/2014 was reviewed and identified the following: I have psychosocial wellbeing problem related to lack of motivation and anxiety. I have hallucinations sometimes about mice crawling on me. I use psychotropic medications. Interventions: allow me to voice my concerns or opinions when I am upset or feeling down; educate me about risks and benefits and the side effects and/or toxic symptoms of anti-depressant drugs being given and staff to monitor and document behaviors daily. However it did not address the use of the as	F 329		

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F 329	Continued From page 13 needed Ativan, non-pharmacological interventions to use prior to administration or the psychotherapy support plan recommendations. On 10/24/2014 at 10:30 a.m., a trained medical assistant (TMA)-C was interviewed. She indicated the resident took the Ativan at least 2-3 times a day and the resident requested it. When asked about non-pharmacological interventions attempted prior to the administration of the medication, the TMA stated R16 did activities, physical therapy, and other things but when the resident wanted the medication, the resident got the medication. TMA-C indicated they document effectiveness but not necessarily why the medication was given or what interventions were attempted prior to giving the medication. On 10/24/2014 at 12:00 p.m. the director of nursing (DON) was interviewed. She stated R16 knew what worked. Non-pharmacological interventions were not identified to be used prior to administering the medication Ativan and the psychotherapy support plan was not identified as well on the resident's care plan.	F 329		
F 356 SS=D	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses.	F 356	F356 1. Staffing is posted daily 2. No residents were affected. 3. Administrator/designee will randomly audit posting. 4. Any concerns identified will be addressed at the facility's Quality Assurance meeting. 5. Compliance date: 12/3/2014	12/3/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245383	A. BUILDING _____ B. WING _____	10/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWATONNA CARE CENTER	201 SOUTHWEST 18TH STREET OWATONNA, MN 55060

(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 356	Continued From page 14 - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to post required staffing information on a daily basis. This had the potential to affect 35 of 35 residents living in the facility at the time of the initial tour, staff and visitors. Findings include: During observation of initial tour on 10/20/14, at 1:12 p.m. surveyors were not able to locate the staff posting of hours. On 10/20/14, at 1:50 p.m. the administrator assisted surveyor to locate the staff posting of hours and the staff posting was dated 8/20/14.	F 356		

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F 356	Continued From page 15 The administrator verified the staff posting was dated 8/20/14 and stated the director of nursing (DON) was responsible for completing them on a daily basis. On 10/20/14 at 2:38 p.m. the DON verified the staff posting of hours was dated 8/20/14. The DON stated she was the staff person responsible for completing them and stated she had completed the postings and placed them in a binder in her office. The DON verified the facility had not posted the staffing hours according to the regulation. During review of policy titled posting direct care daily staffing numbers revised August 2006, revealed the facility would post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents.	F 356		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		

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F 441	Continued From page 16 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their infection control program, lacking monitoring and surveillance of ongoing infections. This had the potential to affect all residents in the facility. Findings include: Infection Control Logs were requested provided and included the following: Review of the facility's infection control logs for January 2014 through October 2014, revealed the logs lacked any data for the months of February 2014 through June 2014. The information included a list of residents with an antibiotic order only. Urinary tract infections (UTIs) which	F 441	F441 1. Though no specific residents were affected there was a potential to affect many. 2. Infection control program has been implemented to include monitoring and surveillance of ongoing infections. 3. Staff will be educated on 12/02/2014 on infection control programs. 4. Director of Nursing/designee will audit residents on antibiotic therapy weekly as able. 5. Any concerns identified will be addressed at the facility's Quality Assurance meeting. 6. Compliance date: 12/3/2014	12/3/14

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F 441	Continued From page 17 occurred did not identify urine culture and sensitivity results that would identify appropriate antibiotic use, and no evidence of a process or outcome surveillance completed. On 10/24/2014 at 2:10 p.m., the director of nursing (DON) identified as the infection control coordinator was interviewed. She stated she monitored room location for each infection to check for trends. She stated she was unable to identify a trend from February 2014 through May 2014 related to no information present. The DON verified she did not record culture and sensitivity results as part of the infection control program and did not trend bacterium types.	F 441		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure that a call light was in working condition for 1 of 30 residents (R65). Findings include: On 10/20/14 at 4:25 p.m. the call light at the bedside for R65 was checked and found to not to "light up" or signal for assistance on the display outside of the room. R65 was not in the room at the time of the call light check. During an interview with licensed practical nurse (LPN)-A on 10/20/14 at 4:25 p.m., LPN-A	F 463	F463 1. R65 call light is in working condition. 2. All call lights have been checked and are in working order. 3. Maintenance director/designee will audit random call lights weekly for proper working condition. 4. Any concerns identified will be addressed at the facility's Quality Assurance meeting. 5. Compliance date: 12/3/2014	12/3/14

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F 463	Continued From page 18 confirmed that the call light did not work. During an interview with the licensed practical nurse (LPN)-B, on 10/20/14 at 4:40 p.m., LPN-B stated that he had already corrected the call light not working. When asked what they do if they find a call light that does not work, LPN-B indicated that they usually will put a note in the maintenance log with details on the issue. The maintenance log was located at the front desk. LPN-B stated that sometimes the call cord gets a "short" in it. LPN-B indicated that he had swapped the call light that wasn't working with another cord from a room that had no resident in it. LPN-B indicated that he would fill out the form to let maintenance know that he did this LPN-B stated that the cords do short out from time to time. The call light was checked again at this time and it was in working condition. During an interview with maintenance, (M)-A on 10/21/14 at 9:58 a.m., M-A stated that he was not aware that R65 had an issue with his call light. M-A and surveyor checked the maintenance book and found that there was no note left for him that the call light had been swapped out of another room. M-A stated that he would check on this. M-A indicated he was not aware of any policy related to call lights found to be not working only that if there is an issue with a call light that someone leaves him a note in the maintenance book. A policy titled Work Orders, Maintenance, dated August, 2010 read: Policy Statement: Maintenance work orders shall be completed in order to establish a priority of maintenance service. 1. In order to establish a priority of maintenance service, work orders must be filled out and forwarded to the Maintenance Director. 2. It shall be the responsibility of the department	F 463		

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F 463	Continued From page 19 directors to fill out and forward such work orders to the Maintenance Director 3. A supply of work orders is maintained at each nurses' station. 4. Work order requests should be placed in the appropriate file basket at the nurses' station. Work orders are picked up daily. 5. Emergency requests will be given priority I making necessary repairs. A policy titled Answering the Call Light, revised October 2010, directed staff to report all defective call lights to the nurse supervisor promptly.	F 463		

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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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Owatonna Care Center 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 By email to: Marlan.Whitney@state.mn.us	K 000	POC ok PS 11-25-14 RECEIVED NOV 24 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shelley Schlesser	Administrator	11/21/14

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.

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

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K 000	Continued From page 1 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. This facility will be surveyed as two separate buildings. Owatonna Care Center is a 1-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1958 and was determined to be of Type II(222) construction. In 1966, addition was constructed to the South Wing, with a partial basement and was determined to be of Type II(111) construction. Because the original building and the 1 addition are of the same type of construction allowed for existing buildings, the facility was surveyed to a Type II (111) building. The facility is fully sprinkled. 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. The facility has a capacity of 55 beds and had a census of 35 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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K 050 K 050 SS=F	Continued From page 2 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 35 residents. Findings include: On facility tour between 1:30 PM and 4:00 PM on 10/20/2014, the review of the fire drills reports for October 2013 to September 2014. The following fire drills were missed: 2014 - 2nd quarter - evening and night shifts 2014 - 3rd quarter - day shift This deficient practice was confirmed by the Facility Maintenance Director (BL) at the time of discovery.	K 050 K 050	K050 1. Fire drills will be conducted at an in increased varied time to ensure all shifts are addressed, also making sure the drills are competed at times that are not convenient for staff. 2. Monitoring will be completed by Administrator/designee with review of times and shifts of drills. 3. Education completed with Maintenance Director 11/20/2014 4. Any concerns identified will be addressed at the facility's Quality Assurance meeting. 5. Compliance date: 12/3/2014	
K 069	NFPA 101 LIFE SAFETY CODE STANDARD	K 069		

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

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K 069 SS=E	Continued From page 3 Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This Standard is not met as evidenced by: Based on documentation review and staff interview, the facility's kitchen cooking hood fire extinguishing system was not maintained in accordance with 2000 NFPA 101 - 9.2.3 and 1998 NFPA 96 section 8.2.. This deficient practice could affect all 35 residents. Findings include: On facility tour between 1:30 PM and 4:00 PM on 10/20/2014, the review of the kitchen hood system inspection documentation for the past 12 months revealed that the kitchen hood was not inspected every 6 months (10/1/13 and 05/29/14). This deficient practice was confirmed by the Facility Maintenance Director (BL) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 069	K069 1. The kitchen hood system will be inspected per regulations of every 6 months. 2. Monitoring will be completed by Maintenance Director/designee 3. Education completed with Maintenance Director 12/02/2014 4. Any concerns identified will be addressed at the Quality Assurance meeting 5. Compliance date: 12/3/2014	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F5383028

PRINTED: 11/06/2014
FORM APPROVED
OMB NO. 0938-0391

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	245383	A. BUILDING 02 - 1992 ADDITION B. WING _____	10/20/2014

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DC: 12-3-14

EDIT: 10-24-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Shelley Schleuning

TITLE: Administrator

(X6) DATE: 11/21/14

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: 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. This facility will be surveyed as two separate buildings. Owatonna Care Center , 1992 addition is a 1-story building with no basement. The 1992 addition was determined to be of Type V (111) construction. The 1992 addition building is fully sprinklered. 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. The facility has a capacity of 55 beds and had a census of 35 at the time of the survey.	K 000	K050 1. Fire Drills will be conducted at an increased varied time to ensure all shifts are addressed, also making sure the drills are completed at time that are not convenient for staff. Also will not miss any drills and will continue to complete on all shifts. 2. Monitoring will be completed by Administrator/designed with review of times and hifts of drills 3. Education completed with Maintenance Director 11/20/2014 4. Any concerns identified will be addressed at the facility's Quality Assurance meeting. 5. Compliance date: 12/3/2014	
K 050 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: 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	K 050		

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	245383	A. BUILDING 02 - 1992 ADDITION B. WING _____	10/20/2014

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OWATONNA CARE CENTER	201 SOUTHWEST 18TH STREET OWATONNA, MN 55060

(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 050	Continued From page 2 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 35 residents. Findings include: On facility tour between 1:30 PM and 4:00 PM on 10/20/2014, the review of the fire drills reports for October 2013 to September 2014. The following fire drills were missed: 2014 - 2nd quarter - evening and night shifts 2014 - 3rd quarter - day shift This deficient practice was confirmed by the Facility Maintenance Director (BL) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 050		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245383	A. BUILDING 02 - 1992 ADDITION B. WING _____	10/20/2014

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