CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: EH43

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY	AGENCY	F	acility ID: 00633
MEDICARE/MEDICAID PROVIDE (L1) 245396 2.STATE VENDOR OR MEDICAID N (L2) 049021100		3. NAME AND AD (L3) CENTRACA (L4) 525 WEST M (L5) MELROSE,	ARE HEALTH SY MAIN STREET			NE VILLA C C (L6) 56352	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	7 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SUI	PPLIER CATEGORY	Y 09 ESRD	02 13 PTIP	(L7) 22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other mplaint
6. DATE OF SURVEY 08 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Othe		02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPIG	CE	FISCAL YEAR ENDING 06/30	DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDO' 18 SNF 18/19 SN 75 (L37) (L38) 16. STATE SURVEY AGENCY REM/	75 (L18) 75 (L17) WN IF 19 SNF (L39)	X A. In Complian Program Re Compliance1. A B. Not in Com Requirements ICF (L42)	equirements Based On: Acceptable POC Appliance with Program and/or Applied Waiv IID (L43)		2345. * Code: 15. FACILI 1861 (e) (Technical Personnel 24 Hour RN 7-Day RN (Rural SNF) Life Safety Code A*	9. Beds/Room (L12) (L15)	tor
Bruce Mel	chert HFE NE	II	08/31/2016	(L19)	Kate J	ohnsTon, Pro	ogram Specialist	09/01/2016 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RE	EGIONAL	OFFICE (OR SINGLE STAT	E AGENCY	()
DETERMINATION OF ELIGIBIL 1. Facility is Eligible to 2. Facility is not Eligib	Participate		IPLIANCE WITH C	IVIL	21.		al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA	-1513)
22. ORIGINAL DATE OF PARTICIPATION 12/01/1986 (L24)	23. LTC AGREEMI BEGINNING (L41)		24. LTC AGREEME ENDING DATE (L25)		VOLUNTAL 01-Merger, 0			ARY eet Health/Safety eet Agreement
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVI A. Suspension of B. Rescind Sus	of Admissions:	(L44) (L45)			nvoluntary Termination ason for Withdrawal	OTHER 07-Provider 00-Active	Status Change
28. TERMINATION DATE:	29	. INTERMEDIARY/C			30. REMAR	RKS		
	(L28)	03001		(L31)				
31. RO RECEIPT OF CMS-1539	(L32)	. DETERMINATION (08/09/2016	OF APPROVAL DAT	(L33)		ed 09/13/2016 Co.	VAL	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245396 September 1, 2016

Mr. Gerry Gilbertson, Administrator Centracare Health System - Melrose Pine Villa Care Center 525 West Main Street Melrose, MN 56352

Dear Mr. Gilbertson:

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 August 9, 2016 the above facility is certified for or recommended for:

75 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 75 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,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered September 1, 2016

Mr. Gerry Gilbertson, Administrator Centracare Health System - Melrose Pine Villa Care Center 525 West Main Street Melrose, MN 56352

RE: Project Number S5396025

Dear Mr. Gilbertson:

On July 15, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 30, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On August 31, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on August 1, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 30, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 9, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 30, 2016, effective August 9, 2016 and therefore remedies outlined in our letter to you dated July 15, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

				POST	-CERT	IFIC	ATION	N RE	VISIT RE	PORT	,		
	R / SUPPLIE		LIA /	MULTIPLE CONS	TRUCTION							DATE O	F REVISIT
245396	CATION NUM	//BER	Y1	A. Building B. Wing							Y2	8/31/20	16 _{Y3}
NAME OF	FACILITY							STREE	T ADDRESS, CIT	Y, STATE, ZIF	CODE		
CENTRA	CARE HEA	ALTH	SYSTEM	- MELROSE PIN	E VILLA C	С		525 WE	ST MAIN STREE	Т			
								MELRO	SE, MN 56352				
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Reg.#	483.10(g)(1)		Completed	Reg. #	483.65			Completed	Reg. #	483.70(h)		Completed
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REVIEWEI	D BY		REVIEW (INITIAL	ED BY	DATE		TITLE					DATE	

6/30/2016

FOLLOWUP TO SURVEY COMPLETED ON

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

YES NO

POST-CERTIFICATION REVISIT REPORT

PROVIDE IDENTIFIC 245396				MULTIPLE CONS A. Building 01 - B. Wing	TRUCTION - MAIN BUIL	DING 0	1				Y2	DATE 0 8/1/201	F REVISIT
NAME OF	FACILITY	,	- ''	-				STREET	ADDRESS, CIT	Y, STATE, ZIP			10
			SYSTEM	- MELROSE PII	NE VILLA C	С		1	T MAIN STREE				
								MELROS	E, MN 56352				
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Reg.#	NFPA 10	1		Completed	Reg. #	NFPA 1	01		Completed	Reg. #			Completed
LSC	K0027			07/14/2016	LSC	K0050			07/05/2016	LSC			
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FOLLOWUP TO SURVEY COMPLETED ON [6/28/2016						DEFICIENCIES MS-2567) SEN			☐ YES	в 🔲 но			

POST-CERTIFICATION REVISIT REPORT

FOLLOWUP TO SURVEY COMPLETED ON [6/28/2016							D DEFICIENCIES (CMS-2567) SEN			YES	i No		
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CENTRA	CARE H	EALTH	SYSTEM	- MELROSE PIN	IE VILLA C	С		1	ST MAIN STREE OSE, MN 56352	T			
NAME OF	FACILITY	· · · · · · · · · · · · · · · · · · ·	TI	<u> </u>				STREE	T ADDRESS, CIT	Y, STATE, ZIP	CODE Y2		13
IDENTIFIC 245396			Y1		2007 ADDI	TION					V0	8/1/2016	
PROVIDE	R / SUPPI	LIER / C	LIA /	MULTIPLE CONS	TRUCTION							DATE OF	FREVISIT



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered September 1, 2016

Mr. Gerry Gilbertson, Administrator Centracare Health System - Melrose Pine Villa Care Center 525 West Main Street Melrose, MN 56352

Re: Reinspection Results - Project Number S5396025

Dear Mr. Gilbertson:

On August 31, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 31, 2016, with orders received by you on . At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

			STA	ATE FORM: REV	/ISIT REPORT				
	R / SUPPLIER / CLIA / CATION NUMBER	MULTIPLE CONS A. Building						DATE OF REVI	SIT
00633	Y	B. Wing					Y2	8/31/2016	Y3
	FACILITY				STREET ADDRESS, CIT		DE		
CENTRA	CARE HEALTH SYSTE	EM - MELROSE PIN	NE VILLA C	С	525 WEST MAIN STREE MELROSE, MN 56352	ΞT			
corrective	ort is completed by a State action was accomplishtion prefix code previousm).	ned. Each deficiend	cy should be	fully identified using	ng either the regulation	or LSC provision	number and	the	
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DATE DATE **REVIEWED BY** REVIEWED BY SIGNATURE OF SURVEYOR STATE AGENCY (INITIALS) BF/KJ 32613 09/01/2016 08/31/2016 DATE TITLE DATE REVIEWED BY REVIEWED BY CMS RO (INITIALS) CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF FOLLOWUP TO SURVEY COMPLETED ON UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

YES NO

6/30/2016

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: EH43

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PA	RT I - TO BE COM	PLETED BY T	HE STAT	E SURVEY A	AGENCY	F	acility ID: 00633
MEDICARE/MEDICAID PROV (L1) 245396 STATE VENDOR OR MEDICAI (L2) 049021100		3. NAME AND AD (L3) CENTRACA (L4) 525 WEST M (L5) MELROSE,	RE HEALTH SY IAIN STREET			E VILLA C C 6) 56352	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	2 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE (L9)	OF OWNERSHIP	7. PROVIDER/SUI	PPLIER CATEGORY	Y 09 ESRD	<u>02</u> (I	L7) 22 CLIA	7. On-Site Visit 8. Full Survey After Con	9. Other
	06/30/2016 (L34) (L10) TJC Other	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING : 06/30	DATE: (L35)
11. LTC PERIOD OF CERTIFICAT From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds	75 (L18) 75 (L17)	X B. Not in Com	nce With quirements		2. To 3. 24 4. 7-	royed Waivers Of The echnical Personnel 4 Hour RN -Day RN (Rural SNF) ife Safety Code B*	Following Requirements: 6. Scope of Servic 7. Medical Direct 8. Patient Room S 9. Beds/Room (L12)	or
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17. SURVEYOR SIGNATURE		Date :			18. STATE SU	JRVEY AGENCY AP	PROVAL	Date:
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	PART II - T	O BE COMPLETE	D BY HCFA RI	EGIONAL	OFFICE OF	R SINGLE STAT	E AGENCY	
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28. TERMINATION DATE:		29. INTERMEDIARY/C	CARRIER NO.		30. REMARK	S		
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PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered July 15, 2016

Mr. Gerry Gilbertson, Administrator Centracare Health System - Melrose Pine Villa Care Center 525 West Main Street Melrose, Minneosta 56352

RE: Project Number S5396025

Dear Mr. Gilbertson:

On June 30, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

Remedies - the type of remedies that will be imposed with the authorization of the

Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<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:

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing & Certification
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
Fax: (320)223-7348

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 August 9, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 9, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of

compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 30, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 30, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those

preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

PRINTED: 08/04/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		SURVEY PLETED
		245396	B. WING _			06	/30/2016
	ROVIDER OR SUPPLIER	- MELROSE PINE VILLA C C		52	REET ADDRESS, CITY, STATE, ZIP CODE 5 WEST MAIN STREET ELROSE, MN 56352		
(X4) ID PREFIX TAG	(EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION S		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	correction (POC) will serve	F	000			
	as your allegation of one Department's acceptate enrolled in ePOC, you at the bottom of the fi	compliance upon the ance. Because you are ur signature is not required rst page of the CMS-2567 submission of the POC will					
F 167	on-site revisit of your validate that substant regulations has been your verification.	cceptable electronic POC, an facility may be conducted to cial compliance with the attained in accordance with	F	167			7/25/16
SS=C	A resident has the rig the most recent surve Federal or State surv correction in effect wi The facility must mak examination and mus	the to examine the results of ey of the facility conducted by eyors and any plan of the respect to the facility. The the results available for the post in a place readily and must post a notice of					
	by: Based on observation review, the facility fail recent survey results of their availability way had the potential to a currently residing in the	n, interview and document led to ensure the most were posted and/or a notice as readily accessible. This ffect all 75 residents he facility, families, and sh to review this information.			The most recent survey results were placed on the entryway table, an easily accessible area on 6/30/2016. A sign was made notifying staff, residents, and visitors where the most recent survey results could be located and posted at entryway doors and also in the Activity	d	
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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

(X6) DATE

Electronically Signed

07/25/2016

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

Facility ID: 00633

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		245396	B. WING		06/30/2016
	ROVIDER OR SUPPLIER	EM - MELROSE PINE VILLA C C		STREET ADDRESS, CITY, STATE, ZIP CO 525 WEST MAIN STREET MELROSE, MN 56352	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE COMPLETION HE APPROPRIATE DATE
F 167	8:46 a.m. the mos not be located, no to identify the locaresults. When interviewed family member (FI aware of where the facility. During interview of stated she was undersults were located seen the results processed to be posted however they were added, "I don't know they were added, "I don't know they were and placed for the beauty of the beauty o	our of the facility on 6/27/16, at at recent survey results could ar was there signage observed ation/availability of the survey on 6/28/16, at 12:58 p.m. M)-D stated they were not e survey results were located in an 6/28/16, at 4:08 p.m. R55 haware where the current survey red in the facility, nor had never osted. Further, R55 stated the dinever been discussed during diding, "I would like to see the con 6/30/16, at 10:06 a.m. (NA)-H stated the survey results by the entrance to the facility, e no longer there and NA-H ow where they are." In on 6/30/16, at 10:12 a.m. binder from a desk near the red it on the table by the main contained the most recent on 6/30/16, at 11:28 a.m. the (DON) stated the most recent ould be, "Readily available," and they had been placed in a desk the DON stated she would place	F 16	Room. Education was provion regulations regarding the most recent survey results with Wednesday August 20th, 20 Education will also be provion meetings on 8/2/2016 and 8 audit of the location of the presults will be completed 5X weeks or until compliance is Director of Nursing will monion of this audit. The results of this monitorin brought forward to the qualitic committee. Completion date: July 25, 2	e posting of the via e-mail on 016. ded at staff 6/4/2016. An ast survey 6 week X 6 6 met. The itor the results g will be ty assurance

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		245396	B. WING _		06/30/2016
	ROVIDER OR SUPPLIER	MELROSE PINE VILLA C C		STREET ADDRESS, CITY, STATE, ZIP CODE 525 WEST MAIN STREET MELROSE, MN 56352	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
F 167 F 441 SS=D	signage up in the facility Posting of Spolicy dated 5/15, ide make the survey resuin a place readily accomust post a notice of 483.65 INFECTION OF SPREAD, LINENS The facility must estal Infection Control Prografe, sanitary and control help prevent the deformance of disease and infection (a) Infection Control Formula The facility must estal Program under which (1) Investigates, control in the facility; (2) Decides what program under which (3) Maintains a record actions related to infection the Infection Control Formula The facility; (b) Preventing Spread (1) When the Infection determines that a reservance in the reservance of the Infection determines that a reservance in the reservance of the Infection determines that a reservance in the reservance of the Infection determines that a reservance in the reservance of the Infection determines that a reservance of the Infection determin	lity to tell residents and ults were located. tate/Federal Survey Results ntified the facility should lits available for examination essible to residents and their availability. CONTROL, PREVENT blish and maintain an gram designed to provide a mfortable environment and evelopment and transmission on. Program blish an Infection Control it - rols, and prevents infections cedures, such as isolation, an individual resident; and d of incidents and corrective ctions.	F 1	67	8/4/16
	communicable diseast from direct contact will direct contact will tran (3) The facility must r	prohibit employees with a see or infected skin lesions the residents or their food, if asmit the disease. The resident contact for which			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245396	B. WING		06/30/2016
	ROVIDER OR SUPPLIER	MELROSE PINE VILLA C C		STREET ADDRESS, CITY, STATE, ZIP CODE 525 WEST MAIN STREET MELROSE, MN 56352	33.03.23.13
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 441	transport linens so as infection. This REQUIREMENT by: Based on observation review, the facility fail hygiene was complet contamination for 2 or observed to receive of the facility fail hygiene was complet contamination for 2 or observed to receive of the facility fail hygiene was complet contamination for 2 or observed to receive of the facility fail hygiene was completed. R87's quarterly Minim 5/12/16, identified R8 impairment, and need person for toileting. During observation or nursing assistant (NA restroom, and helped assisted R87 to stand gloves on and complete was visible stoom NA-D removed her glip pants before assisting NA-D did not wash he sanitizer after removing then re-applied R87's handed R87 a clean to the facility of the	le, store, process and to prevent the spread of is not met as evidenced in, interview and document ed to ensure adequate hand ed to reduce the risk of 5 residents (R87, R79) ares. Inum Data Set (MDS) dated 7 had severe cognitive ded extensive assist by one in 6/29/16, at 10:25 a.m. I)-D assisted R87 to the her sit on the toilet. NA-D is up from the toilet with eted with cleaning wipes, oves and pulled up R87's go her to sit in her wheelchair. For hands or use a handing her soiled gloves. NA-D oxygen cannula, and issue after pushing her bathroom before using a	F 44	Education was provided to all staff via e-mail on July 20th, 2016 regarding appropriate times for hand hygiene. Education will also be provided at staff meetings on August 2nd and August 4 2016. Hand Hygiene posters were pla throughout the facility to remind staff about hand hygiene. Hand hygiene wireinforced at new employee orientation Hand hygiene audits will be conducted nursing staff 3 X weekly x 3 months, the 1X week for 3 months or until compliar is met. The Director of Nursing or her designee will monitor the results of the hand hygiene audits. The results of this monitoring will be brought forward to the quality assurance committee. Completion date: August 4, 2016.	th, ced Il be n. I by nen nce

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		(X3) DATE SURVEY COMPLETED
	245396	B. WING		06/30/2016
	M - MELROSE PINE VILLA C C		STREET ADDRESS, CITY, STATE, ZIP CO 525 WEST MAIN STREET MELROSE, MN 56352	· · · · · · · · · · · · · · · · · · ·
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE COMPLETION DATE
Immediately after the interviewed and state hands or use a hand soiled gloves. Furth received hand hygie	ne observation NA-D was ted she did not wash her d sanitizer after removing her ner, NA-D stated she had ene education in a recently	F 44	11	
identified R79 had sand required extens of daily living, included bathing, toileting, earning assistant (National toileting). R79 had to NA-A removed her sperineal care using the soiled gloves artrash. NA-A then as make-up, combing liglasses without was removing the soiled left the room and us. When interviewed to 8:10 a.m. NA-A statt completed upon entroom, or if gloves be during cares. During interview on licensed practical networks.	severe cognitive impairment sive assistance with activities ding dressing, grooming, ating, and personal cares. on 6/29/16, at 7:46 a.m. IA)-A assisted R79 with been incontinent of urine, and soiled brief and completed gloved hands. NA-A removed and disposed of them in the assisted R79 with applying her hair and applying her eye shing her hands after gloves. At 8:07 a.m. NA-A seed hand sanitizer. on 6/29/16, at approximately ted hand hygiene should be tering and leaving a resident ecome visibly soiled with stool 6/30/16, at 4:31 p.m. urse (LPN)-A stated hand			
1	SUMMARY SI (EACH DEFICIEN REGULATORY OF REGU	ROVIDER OR SUPPLIER CARE HEALTH SYSTEM - MELROSE PINE VILLA C C SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 Immediately after the observation NA-D was interviewed and stated she did not wash her hands or use a hand sanitizer after removing her soiled gloves. Further, NA-D stated she had received hand hygiene education in a recently completed infection control training. R79's significant change MDS dated 4/28/16, identified R79 had severe cognitive impairment and required extensive assistance with activities of daily living, including dressing, grooming, bathing, toileting, eating, and personal cares. During observation on 6/29/16, at 7:46 a.m. nursing assistant (NA)-A assisted R79 with toileting. R79 had been incontinent of urine, and NA-A removed her soiled brief and completed perineal care using gloved hands. NA-A removed the soiled gloves and disposed of them in the trash. NA-A then assisted R79 with applying make-up, combing her hair and applying her eye glasses without washing her hands after removing the soiled gloves. At 8:07 a.m. NA-A left the room and used hand sanitizer. When interviewed on 6/29/16, at approximately 8:10 a.m. NA-A stated hand hygiene should be completed upon entering and leaving a resident room, or if gloves become visibly soiled with stool	ROVIDER OR SUPPLIER CARE HEALTH SYSTEM - MELROSE PINE VILLA C C SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 Immediately after the observation NA-D was interviewed and stated she did not wash her hands or use a hand sanitizer after removing her soiled gloves. Further, NA-D stated she had received hand hygiene education in a recently completed infection control training. R79's significant change MDS dated 4/28/16, identified R79 had severe cognitive impairment and required extensive assistance with activities of daily living, including dressing, grooming, bathing, toileting, eating, and personal cares. During observation on 6/29/16, at 7:46 a.m. nursing assistant (NA)-A assisted R79 with toileting. R79 had been incontinent of urine, and NA-A removed her soiled brief and completed perineal care using gloved hands. NA-A removed the soiled gloves and disposed of them in the trash. NA-A then assisted R79 with applying make-up, combing her hair and applying her eye glasses without washing her hands after removing the soiled gloves. At 8:07 a.m. NA-A left the room and used hand sanitizer. When interviewed on 6/29/16, at approximately 8:10 a.m. NA-A stated hand hygiene should be completed upon entering and leaving a resident room, or if gloves become visibly soiled with stool during cares. During interview on 6/30/16, at 4:31 p.m. licensed practical nurse (LPN)-A stated hand	ROVIDER OR SUPPLIER 245396 245396 ROVIDER OR SUPPLIER 2ARE HEALTH SYSTEM - MELROSE PINE VILLA C C SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 4 Immediately after the observation NA-D was interviewed and stated she did not wash her hands or use a hand sanitizer after removing her soiled gloves. Further, NA-D stated she had received hand hygiene education in a recently completed infection control training. R79's significant change MDS dated 4/28/16, identified R79 had severe cognitive impairment and required extensive assistance with activities of daily living, including dressing, grooming, bathing, tolleting, eating, and personal cares. During observation on 6/29/16, at 7.46 a.m. nursing assistant (NA)-A assisted R79 with tolleting. R79 had been incontinent of urine, and NA-A removed the soiled gloves and disposed of them in the trash. NA-A then assisted R79 with applying make-up, combing her hair and applying her eye glasses without washing her hands after removing the soiled gloves. At 8:07 a.m. NA-A left the room and used hand sanitizer. When interviewed on 6/29/16, at approximately 8:10 a.m. NA-A stated hand hygiene should be completed upon entering and leaving a resident room, or if gloves become visibly soiled with stool during cares. During interview on 6/30/16, at 4:31 p.m. licensed practical nurse (LPN)-A stated hand

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
	245396	B. WING		06/30/2016
NAME OF PROVIDER OR SUPPLIER CENTRACARE HEALTH SYST	EM - MELROSE PINE VILLA C C		STREET ADDRESS, CITY, STATE, ZIP CODE 525 WEST MAIN STREET MELROSE, MN 56352	
PREFIX (EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
directed staff to pafter contact with of gloves does not hygiene." Further hygiene should be gloves with care. F 465 483.70(h) SS=D SAFE/FUNCTIONE ENVIRON The facility must panitary, and companitary, and companitary, and companitary, and companitary, and companitary, the facility environment was (R49) whose roomed findings include: R49's quarterly May 3/24/16, identified impairment, and warring. During observations strong urine odor clean commode wathere were no soil trash.	rgiene policy revised 4/15, erform hand hygiene before and each resident adding, "The use it replace the need for hand the policy directed hand the completed after the removal of NAL/SANITARY/COMFORTABL provide a safe, functional, ifortable environment for	F 44		dors, an ail to with ucated d nental ager or on. will eas for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245396	B. WING _			06/	30/2016
	ROVIDER OR SUPPLIER	- MELROSE PINE VILLA C C		52	REET ADDRESS, CITY, STATE, ZIP CODE 25 WEST MAIN STREET ELROSE, MN 56352	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 465	4:35 p.m. a large fan middle of R49's room However, a strong, for remained present in the During interview on 6 assistant (NA)-B state of urine, and the odor thing." NA-B stated Finder room by herself disometimes would not incontinence. Furthe housekeeping had trie odor, but it had not her When interviewed on maintenance person room had a urine sme to address it beside of During interview on 6 director of nursing (Dinaware R49's room	had been placed in the , and the carpet was damp. Full, malodorous, urine odor the room. /30/16, at 4:35 p.m., nursing ed R49's room had an odor of had been, "An ongoing R49 used the commode in uring the night hours, but make it in time and have or, NA-B stated ed before to remove the eliped with the odor. 6/30/16, at 4:41 p.m. the interpretation of the carpeting. /30/16, at 5:18 p.m. the ON) stated she was smelled of urine. Further, arpet should be replaced to	F	465	monitoring will be brought forward to the quality assurance committee. Completion date: August 9, 2016.	ne	

F5394024

PRINTED: 07/26/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A: BUILDING 01 - MAIN BUILDING 01 245396 B. WING 06/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **525 WEST MAIN STREET** CENTRACARE HEALTH SYSTEM - MELROSE PINE VILLA C C MELROSE, MN 56352 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on June 28, 2016. At the time of this survey, Building 01 of Centracare Health System Melrose (Pine Villa) was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145

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

St Paul, MN 55101-5145, or

TITLE

(X6) DATE

Electronically Signed

0//25/2016

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
LANGE OF F	PROVIDER OR SUPPLIER	245396	B, WING	TREET ADDRESS, CITY, STATE, ZIP CODE	06/2	28/2016
		TEM - MELROSE PINE VILLA C	52	25 WEST MAIN STREET IELROSE, MN 56352		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
K 000	Continued From pa	age 1	K 000			
	Angela.Kappenma	itney@state.mn.us> and				
		RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION:				
	1. A description of to correct the defic	what has been, or will be, done iency.	Э			
	2. The actual, or pr	oposed, completion date.				
	responsible for cor	r title of the person rection and monitoring to ence of the deficiency				
	(Pine Villa) was co The original buildin one-story in height	tracare Health System Melrose nstructed as follows: g was constructed in 1961, is , has no basement, is fully as determined to be of Type n;	ð			
	The 1969 addition basement, is fully s determined to be of the 1987 addition basement, is fully s determined to be of the 1994 addition basement, is fully s	is one-story in height, has no sprinklered, and was f Type II(111) construction; is one-story in height, has no sprinklered, and was f Type V(111) construction; is one-story in height, has no sprinklered, and was f Type II(111) construction.		*		
	detection in the cor	re alarm system with smoke ridors and spaces open to the nonitored for automatic fire				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION IG 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245396	B. WING		06	3/28/2016	
	PROVIDER OR SUPPLIER	TEM - MELROSE PINE VILLA C C		STREET ADDRESS, CITY, STATE, ZIP C 525 WEST MAIN STREET MELROSE, MN 56352			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE	
K 000	capacity of 75 beds time of the survey. The requirement a NOT MET as evide	ation. The facility has a s and had a census of 75 at t 42 CFR, Subpart 483.70(a) is enced by:	K 00				
K 027 SS=F	Door openings in secondarios accordance with 19.3.7.7 This STANDARD Door openings in 20-minute fire protective plates the from the bottom of Horizontal sliding of Doors are self-closs accordance with 19.3.7.7 This STANDARD Door openings in 20-minute fire protective plates the from the bottom of Horizontal sliding of Doors are self-closs accordance with 19.00 accordance with 19.3.7.7 Findings include: During the facility to 9:00 am and 1:00 accordance with 19.00 am and 1:00 accordance with 19.3.7.7	our on 06/28/2016 between PM, revealed that: ors near the Dining Room would	K O	Door was repaired and now Maintenance manager will i		7/14/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
	245396	B. WING_		06/2	8/2016
	EM - MELROSE PINE VILLA C C		STREET ADDRESS, CITY, STATE, ZIP CODE 525 WEST MAIN STREET MELROSE, MN 56352	•	
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
Continued From pa	ge 3	K 02	27		
Fire drills include the signal and simulation conditions. Fire drill times under varying on each shift. The sand is aware that droutine. Responsibit conducting drills is persons who are quality where drills are conditions. Fire drills include the signal and simulation conditions. Fire drill times under varying on each shift. The sand is aware that droutine. Responsibit conducting drills is persons who are quality where drills are conditions are quality are conditions.	the transmission of a fire alarm on of emergency fire is are held at unexpected in conditions, at least quarterly staff is familiar with procedures rills are part of established lity for planning and assigned only to competent utualified to exercise leadership. Inducted between 9:00 PM and innouncement may be used alarms. It is not met as evidenced by: The transmission of a fire alarm on of emergency fire is are held at unexpected in conditions, at least quarterly staff is familiar with procedures rills are part of established dility for planning and assigned only to competent utualified to exercise leadership. Inducted between 9:00 PM and innouncement may be used	K 08	Drills are held monthly. Policy now to document department when attedrills. Education sent via e-mail to to document their department.	v states ending all staff	7/5/16
Findings include:					
	PROVIDER OR SUPPLIER CARE HEALTH SYST SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa NFPA 101 LIFE SA Fire drills include th signal and simulation conditions. Fire drill times under varying on each shift. The sand is aware that droutine. Responsible conducting drills is persons who are que Where drills are conficted from the signal and simulating on each shift. The sand is aware that droutine. Responsible conducting drills is persons who are que where drills are conficted from the signal and simulating on the signal signa	TONITION NUMBER: 245396 PROVIDER OR SUPPLIER CARE HEALTH SYSTEM - MELROSE PINE VILLA C C SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2	ROVIDER OR SUPPLIER CARE HEALTH SYSTEM - MELROSE PINE VILLA C C SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 K 02 NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. 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Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2	PROVIDER OR SUPPLIER CARE HEALTH SYSTEM - MELROSE PINE VILLA C C SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is mulation of emergency fire conditions. Fire drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2	A BUILDING 01 - MAIN BUILDING 01 245396 245396 B WING STREET ADDRESS, CITY, STATE, ZIP CODE 528 WEST MAIN STREET MELROSE, MN 56352 SUMMARY STATEMENT OF DEFICIENCIES (EACH OPECICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 K 027 NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 Drills are held monthly. Policy now states to document department when attending drills. Education sent via e-mail to all staff to document department. Maintenance manager will monitor. Maintenance manager will monitor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DAT COM	(X3) DATE SURVEY COMPLETED	
		245396	B. WING	<u>=</u>	06/	/28/2016
	PROVIDER OR SUPPLIER	EM - MELROSE PINE VILLA C C		STREET ADDRESS, CITY, STATE, ZIP CODE 525 WEST MAIN STREET MELROSE, MN 56352		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 050	on 06/28/2016 between record review reveal connected throught	our and documentation review ween 9:00 AM and 1:00 PM, aled the fire alarm system is out the nursing home and the nursing home were only	KO			

75396024

PRINTED: 07/26/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 02 - 2007 ADDITION B: WING 245396 06/28/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **525 WEST MAIN STREET** CENTRACARE HEALTH SYSTEM - MELROSE PINE VILLA C C MELROSE, MN 56352 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 **FIRE SAFETY** THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on April 21,2015. At the time of this survey, Building 02 of Centracare Health System Melrose (Pine Villa) was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES** (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or

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

TITLE

(X6) DATE

Electronically Signed

07/25/2016

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

Facility ID: 00633

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION 2 - 2007 ADDITION		E SURVEY PLETED
NAME OF	PROVIDER OR SUPPLIER	245396	B. WING	REET ADDRESS, CITY, STATE, ZIP CODE	06/2	28/2016
		TEM - MELROSE PINE VILLA C C	52	5 WEST MAIN STREET ELROSE, MN 56352		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	Continued From pa	age 1	K 000			
	Angela.Kappenma	itney@state.mn.us> and				
		RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION:				
	A description of to correct the defication.	what has been, or will be, done iency.				
	2. The actual, or pr	oposed, completion date.				
	responsible for cor	or title of the person rection and monitoring to ence of the deficiency				
	(Pine Villa) consist addition. The addi no basement, is fu	tracare Health System Melrose s of the 2007 resident wing tion is one-story in height, has lly sprinklered, and was of Type V(111) construction.				
	detection in the co- corridors which is a department notifica	re alarm system with smoke rridors and spaces open to the monitored for automatic fire ation. The facility has a s and had a census of 75 at				
K 027	NOT MET as evide	t 42 CFR, Subpart 483.70(a) is enced by: AFETY CODE STANDARD	K 027			7/14/16
SS=F	Doors in smoke ba	arriers have at least a 20 minute g or are at least 1 3/4 inch				

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	PLE CONSTRUCTION G 02 - 2007 ADDITION	(X3) DATE SURVEY COMPLETED	
		245396	B. WING		06/28/2016	
	PROVIDER OR SUPPLIER	FEM - MELROSE PINE VILLA C C		STREET ADDRESS, CITY, STATE, ZIP CODE 525 WEST MAIN STREET MELROSE, MN 56352		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 027	protective plates the from the bottom of Horizontal sliding of Swinging doors shadoor swings in an obe self-closing and are required at the latching is not required at the latching is not required. This STANDARD Doors in smoke be minute fire protections thick solid bor protective plates the from the bottom of Horizontal sliding of Swinging doors shadoor swings in an obe self-closing and are required at the latching is not required.	age 2 core wood. Non- rated at do not exceed 48 inches the door are permitted. loors comply with 7.2.1.14. all be arranged so that each opposite direction. Doors shall rabbets, bevels or astragals meeting edges. Positive ired. 18.3.7.5, 18.3.7.6, is not met as evidenced by: arriers have at least a 20 on rating or are at least 1 3/4 aded core wood. Non- rated lat do not exceed 48 inches the door are permitted. loors comply with 7.2.1.14. all be arranged so that each opposite direction. Doors shall rabbets, bevels or astragals meeting edges. Positive ired. 18.3.7.5, 18.3.7.6,	K 027	Door was repaired and now clo Maintenance manager will moni		
K 050 SS=D	9:00 am and 1:00 I Smoke barrier doo close when tested. NFPA 101 LIFE SA Fire drills include the signal and simulaticonditions. Fire drill times under varying on each shift. The and is aware that of	our on 06/28/2016 between PM, revealed that: rs in Villa Court would not AFETY CODE STANDARD ne transmission of a fire alarm on of emergency fire alarm of emergency fire alarm on of	K 050			7/5/16

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	02 - 2007 ADDITION		
		245396	B. WING		06/2	28/2016
	PROVIDER OR SUPPLIER	TEM - MELROSE PINE VILLA C	5	TREET ADDRESS, CITY, STATE, ZIP CODE 25 WEST MAIN STREET MELROSE, MN 56352		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
K 050	persons who are of Where drills are consisted of audible 18.7.1.2, 19.7.1.2 This STANDARD Fire drills include signal and simulat conditions. Fire drills include and is aware that croutine. Responsit conducting drills is persons who are conducting drills are conducted of audible 18.7.1.2, 19.7.1.2 Findings include:	assigned only to competent qualified to exercise leadership. onducted between 9:00 PM and announcement may be used alarms. is not met as evidenced by: the transmission of a fire alarmion of emergency fire ills are held at unexpected ag conditions, at least quarterly staff is familiar with procedures drills are part of established bility for planning and assigned only to competent qualified to exercise leadership. Inducted between 9:00 PM and announcement may be used alarms. It cour and documentation review ween 9:00 AM and 1:00 PM, ealed the fire alarm system is nout the nursing home and the nursing home were only	3	Drills are held monthly. Policy to document department when drills. Education sent via e-mail to document their department. Maintenance manager will mor	attending to all staff	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted July 15, 2016

Mr. Gerry Gilbertson, Administrator Centracare Health System - Melrose Pine Villa Care Center 525 West Main Street Melrose, Minnesota 56352

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5396025

Dear Mr. Gilbertson:

The above facility was surveyed on June 27, 2016 through June 30, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Brenda Fischer, Unit Supervisor at (320)223-7338.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility

Licensing and Certification File

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPLE			
		00633	B. WING		06/3	0/2016
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STA	TE, ZIP CODE	1 00/0	0/2010
CENTRAC	CARE HEALTH SYSTEM -	MELROSE PINE VI	ST MAIN STREET	•		
OLIVINAC	T	MELRO	SE, MN 56352			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEN	TION*****				
	NH LICENSING CO	ORRECTION ORDER				
	144A.10, this correction pursuant to a survey. Found that the deficier herein are not correct not corrected shall be with a schedule of fine the Minnesota Depart. Determination of where corrected requires contended requires contended and MN Rule. When a rule contains comply with any of the lack of compliance. Line-inspection with any result in the assessments.	ther a violation has been mpliance with all				
	that may result from norders provided that at the Department within notice of assessment INITIAL COMMENTS You have agreed to preceipt of State licens the Minnesota Depart Informational Bulletin	articipate in the electronic ure orders consistent with ment of Health 14-01, available at e.mn.us/divs/fpc/profinfo/inf icensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00633		B. WING		06	/30/2016
NAME OF P	ROVIDER OR SUPPLIER			RESS, CITY, STA			
CENTRAC	CARE HEALTH SYSTEM	MELROSE PINE VI	525 WEST MELROSE,	MAIN STREET MN 56352			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 000	you electronically. Al is necessary for State enter the word "correctext. You must then in State licensure proce completion date, the corrected prior to elect Minnesota Department." On June 27-30, 2016 Department's staff, vithe following correction Please indicate in you correction that you have and identify the date of Minnesota Department the State Licensing Confederal software. Tag assigned to Minnesota Nursing Homes. The assigned tag nur column entitled "ID Fostatute/rule out of con "Summary Statement and replaces the "To correction order. This findings which are in after the statement, "evidence by." Following are the Suggested Matter Sug	orders being submitter though no plan of corre a Statutes/Rules, please cted" in the box available dicate in the electronic ass, under the heading date your orders will be ctronically submitting to not of Health. surveyors of this sited the above provide on orders are issued. Our electronic plan of the reviewed these ordewhen they will be compared to the state statutes/rules for the prefix Tag." The state and the prefix Tag. The state of Deficiencies column Comply" portion of the column also includes the violation of the state state state and the surveyors finding the STATES, OF CORRECTION." TAL DEFICIENCIES ON	ection e e ele for the er and ers, eleted. eting or left n the eatute gs f THE	2 000			

Minnesota Department of Health

STATE FORM 6899 EH4311 If continuation sheet 2 of 7

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED			
		00633		B. WING		06/30/2016
NAME OF B	20,455, 05, 01,551,155		070557.400	DE00 0171/ 071	TE 710 0005	1 00.00.2010
NAME OF PI	ROVIDER OR SUPPLIER			RESS, CITY, STA		
CENTRAC	ARE HEALTH SYSTEM -	MELROSE PINE VI		MAIN STREET MN 56352		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETE
2 000	Continued From page	2		2 000		
		IREMENT TO SUBMIT ION FOR VIOLATIONS STATUTES/RULES.				
21390	MN Rule 4658.0800 S	Subp. 4 A-I Infection Co	ontrol	21390		
	control program must procedures which pro A. surveillance be collection to identify n residents; B. a system for decontrol of outbreaks of C. isolation and preduce risk of transming D. in-service educe prevention and control E. a resident head immunization program defined in part 4658.0 procedures of resident the prevention and treating from the products, including a defined in part 4658.0 G. a system for resproducts which affect disinfectants, antisept incontinence products. I. methods for macurrent standards of prevention to identify the products of products and the products of products	vide for the following: ased on systematic data osocomial infections in etection, investigation, if infectious diseases; arecautions systems to assion of infectious agercation in infection oil; at the program including a n, a tuberculosis program at the care practices to assion and implementation of infection control tuberculosis program at 1815; eviewing antibiotic use; eview and evaluation of infection control, such ics, gloves, and	and nts; n nm as st in of bl ns f as			
	by:	, interview and docume				

Minnesota Department of Health

STATE FORM 6899 EH4311 If continuation sheet 3 of 7

PRINTED: 07/15/2016 FORM APPROVED

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION		E SURVEY PLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.		A. BUILDING: _		COM	PLETED
		00633		B. WING		06	6/30/2016
NAME OF P	ROVIDER OR SUPPLIER	STF	REET ADDI	RESS, CITY, STA	TE, ZIP CODE		
CENTRAC	CARE HEALTH SYSTEM	- MELROSE PINE VI	5 WEST I	MAIN STREET			
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	ME	LROSE,	MN 56352			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21390	Continued From page	e 3		21390			
	hygiene was complet	led to ensure adequate han ed to reduce the risk of f 5 residents (R87, R79) cares.	nd				
	Findings include:						
	5/12/16, identified R8 impairment, and need person for toileting. During observation or nursing assistant (NA restroom, and helped assisted R87 to stand gloves on and complethere was visible stoon NA-D removed her glipants before assisting NA-D did not wash he sanitizer after removithen re-applied R87's handed R87 a clean in	num Data Set (MDS) dated 7 had severe cognitive ded extensive assist by one on 6/29/16, at 10:25 a.m. A)-D assisted R87 to the 1 her sit on the toilet. NA-D d up from the toilet with eted with cleaning wipes, of on the cleansing wipes, over and pulled up R87's g her to sit in her wheelchaiter hands or use a hand ang her soiled gloves. NA-D is oxygen cannula, and tissue after pushing her bathroom before using a	ir.				
	interviewed and state hands or use a hand soiled gloves. Further received hand hygien completed infection of R79's significant chard identified R79 had seand required extensive of daily living, including	observation NA-D was ed she did not wash her sanitizer after removing her er, NA-D stated she had ne education in a recently					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
		00633	B. WING		06/30/2016				
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE. ZIP CODE	00/30/2010				
525 WEST MAIN STREET									
CENTRAC	CENTRACARE HEALTH SYSTEM - MELROSE PINE VI MELROSE, MN 56352								
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	TION SHOULD BE COMPLETE THE APPROPRIATE DATE				
21390	nursing assistant (NA toileting. R79 had be NA-A removed her so perineal care using gl the soiled gloves and trash. NA-A then ass make-up, combing he glasses without wash removing the soiled g left the room and user. When interviewed on 8:10 a.m. NA-A stated completed upon enter room, or if gloves bed during cares. During interview on 6 licensed practical nurshygiene should be peremoved after incontin. A facility Hand Hygier directed staff to perforafter contact with eac of gloves does not rephygiene." Further, the hygiene should be congloves with care. SUGGESTED METHOM The director of nursin that infection control parts.	n 6/29/16, at 7:46 a.m. a)-A assisted R79 with en incontinent of urine, and oiled brief and completed loved hands. NA-A removed disposed of them in the listed R79 with applying er hair and applying her eye ing her hands after lloves. At 8:07 a.m. NA-A d hand sanitizer. 6/29/16, at approximately d hand hygiene should be ring and leaving a resident come visibly soiled with stool	21390	DEL NOILING I)					
		ure proper hand hygiene and d sufficiently when caring for							

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
NAME OF D	00633 B. WING 06/30/2016							
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 525 WEST MAIN STREET								
CENTRACARE HEALTH SYSTEM - MELROSE PINE VI MELROSE, MN 56352								
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE		
21390	Continued From page 5		21390					
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty-one						
21665	MN Rule 4658.1400 Physical Environment		21665					
	functional, comfortable environment, allowing	t provide a safe, clean, le, and homelike physical g the resident to use to the extent possible.						
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a sanitary environment was maintained for 1 of 1 residents (R49) whose room smelled of urine.							
	Findings include:							
	3/24/16, identified R4	num Data Set (MDS) dated 9 had severe cognitive occasionally incontinent of						
	strong urine odor was clean commode was	n 6/28/16, at 1:43 p.m. a s evident in R49's room. A placed against the wall, and incontinence products in the						
	4:35 p.m. a large fan middle of R49's room	oservation on 6/30/16, at had been placed in the , and the carpet was damp. oul, malodorous, urine odor he room.						
	_	/30/16, at 4:35 p.m., nursing ed R49's room had an odor						

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NAME OF PROVIDER OR SUPPLIER CENTRACARE HEALTH SYSTEM - MELROSE PINE VI MELROSE PINE VI MELROSE, INV 58352 [QQ1] D	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE AND PLAN OF CORRECTION IDENTIFICATION NUM			(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED			
CENTRACARE HEALTH SYSTEM - MELROSE PINE UI S25 WEST MAIN STREET MELROSE, MN 56352 MELROSE, MN 56352	00633			B. WING 06			30/2016			
CALL DEPTICE SUMMARY STATEMENT OF DEPICIENCIES	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE									
PREEIX TAG	I CENTRACARE HEALTH SYSTEM - MELROSE PINE VI									
of urine, and the odor had been, "An ongoing thing." NA-B stated R49 used the commode in her room by herself during the night hours, but sometimes would not make it in time and have incontinence. Further, NA-B stated housekeeping had tried before to remove the odor, but it had not helped with the odor. When interviewed on 6/30/16, at 4:41 p.m. maintenance personnel (MP)-A stated R49's room had a urine smell, and he was unsure how to address it beside changing out the carpeting. During interview on 6/30/16, at 5:18 p.m. the director of nursing (DON) stated she was unaware R49's room smelled of urine. Further, the DON stated the carpet should be replaced to address the odor. A facility policy on resident environment maintenance was not provided. SUGGESTED METHOD OF CORRECTION: The DON or designee could review any policies, procedures or facility processes for reporting a malodorous room for deep cleaning, and make any necessary revisions when deep cleaning is ineffective. Appropriate staff could be educated regarding any changes. The DON or designee could develop a system to monitor staff for compliance. TIME PERIOD FOR CORRECTION: Twenty-one	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FUI		PREFIX	(EACH CORRECTIVE A CROSS-REFERENCED TO	CTION SHOULD BE O THE APPROPRIATE	COMPLETE		
	21665	of urine, and the odor thing." NA-B stated Fher room by herself d sometimes would not incontinence. Furthe housekeeping had triodor, but it had not he When interviewed on maintenance person room had a urine sme to address it beside of During interview on 6 director of nursing (D unaware R49's room the DON stated the caddress the odor. A facility policy on resmaintenance was not SUGGESTED METH DON or designee couprocedures or facility malodorous room for any necessary revision ineffective. Appropriar regarding any change could develop a systecompliance.	had been, "An ongoing R49 used the commode luring the night hours, but make it in time and haver, NA-B stated ed before to remove the elped with the odor. 6/30/16, at 4:41 p.m. held (MP)-A stated R49's ell, and he was unsure helped and helped with the carpeting out the carpeting and helped she was smelled of urine. Further arpet should be replaced sident environment approvided. OD OF CORRECTION: ald review any policies, processes for reporting deep cleaning, and make ons when deep cleaning te staff could be educated as the DON or designer arm to monitor staff for	in ut ve e e e e e e e e e e e e e e e e e e	21665					

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