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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: EKVB

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00644

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245426**

2.STATE VENDOR OR MEDICAID NO.
(L2) **665040600**

3. NAME AND ADDRESS OF FACILITY
(L3) **KODA LIVING COMMUNITY**
(L4) **2255 30TH STREET NW**
(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) **11/01/2010**

6. DATE OF SURVEY **03/18/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **80** (L18)

13.Total Certified Beds **80** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	80			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Maria King, Unit Supervisor 03/28/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 03/28/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00000
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/26/2013
(L33)

DETERMINATION APPROVAL

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

At the time of the January 31, 2013 standard survey the facility was not in substantial compliance with Federal participation requirements. A Post Certification Revisit was completed on March 12, 2013 by the Department of Health by review of the plan of correction and on March 18, 2013 by the Department of ublic Safety and verified correction of the deficiencies issued pursuant to the January 31, 2013 standard survey, effective March 12, 2013. Refer to the CMS 2567b forms for both health and life safety code.

Effective March 12, 2013, the facility is certified for 80 skilled nursing facility beds.

Please note; At the time of the standard survey, the facility's name was Steele County Communities for a Lifetime and was licensed and certified for 108 beds. Effective February 11, 2013 the beds were reduced from 108 beds to 80 beds, with an effective date for the move to the new facility on February 12, 2013.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5426

April 12, 2013

Ms. Terry Schneider, Administrator
Steele County Communities For A Lifetime Inc
1409 South Cedar Avenue
Owatonna, Minnesota 55060

Dear Ms. Schneider:

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 March 12, 2013 the above facility is certified for:

108 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 108 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,

Mark Meath

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4118 Fax #: (651) 215-9697

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

March 28, 2013

Ms. Terry Schneider, Administrator
Steele County Communities For A Lifetime Inc
1409 South Cedar Avenue
Owatonna, Minnesota 55060

RE: Project Number S5426023

Dear Ms. Schneider:

On February 15, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 31, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On March 12, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 18, 2013 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 31, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 12, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 31, 2013, effective March 12, 2013 and therefore remedies outlined in our letter to you dated February 15, 2013, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5426r13

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245426	A. Building B. Wing	3/12/2013

Name of Facility	Street Address, City, State, Zip Code
STEELE COUNTY COMMUNITIES FOR A LIFETIME INC	1409 SOUTH CEDAR AVENUE 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 **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	**03/12/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**03/12/2013**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	**03/12/2013**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	**03/12/2013**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	**03/08/2013**	ID Prefix **F0364** Reg. # **483.35(d)(1)-(2)** LSC	**02/09/2013**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	**03/12/2013**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/MK	03/28/2013	08769	03/12/2013
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
1/31/2013			

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245426	A. Building 01 - MAIN BUILDING 01 B. Wing	3/18/2013

Name of Facility	Street Address, City, State, Zip Code
STEELE COUNTY COMMUNITIES FOR A LIFETIME INC	1409 SOUTH CEDAR AVENUE 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	03/12/2013	ID Prefix Reg. # NFPA 101 LSC K0144	03/12/2013	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/PS	03/2/2013	25822	03/18/2013
CMS RO				

Followup to Survey Completed on: 1/29/2013

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: EKVB

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00644

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245426**

2.STATE VENDOR OR MEDICAID NO.
(L2) **665040600**

3. NAME AND ADDRESS OF FACILITY
(L3) **STEELE COUNTY COMMUNITIES FOR A LIFETIME INC**
(L4) **1409 SOUTH CEDAR AVENUE**
(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) **11/01/2010**

6. DATE OF SURVEY **01/31/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **108** (L18)

13.Total Certified Beds **108** (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
	108			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Elizabeth Sandt, HFE NEII 03/12/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 03/25/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00000
(L31)

30. REMARKS
Posted 3/26/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

At the time of the January 31, 2013 standard survey the facility was not in substantial compliance with Federal participation requirements. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

Please note; At the time of the survey, the faciility's name is as it reflects above. The provider is in the process of a facility name change and move to the new facility.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 5815

February 15, 2013

Ms. Terry Schneider, Administrator
Steele County Communities For A Lifetime Inc
1409 South Cedar Avenue
Owatonna, Minnesota 55060

RE: Project Number S5426023

Dear Ms. Schneider:

On January 31, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Maria King
Minnesota Department of Health
Mankato Place
12 Civic Center Plaza, Suite 2105
Mankato, Minnesota 56001-7789

Telephone: (507) 344-2716

Fax: (507) 344-2723

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 March 12, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 12, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

Your PoC must:

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 1, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 31, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Maria King, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (507) 344-2716 Fax: (507) 344-2723

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEELE COUNTY COMMUNITIES FOR A LIFETIME INC	1409 SOUTH CEDAR AVENUE 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	F 279 1. Resident #88 has discharged. 2. All resident care plans and fall risk observations in the electronic health record will be reviewed to ensure the inclusion of current fall interventions. 3. Licensed staff will receive reeducation on policy regarding completion of fall risk assessment and care plan development and inclusion of fall history for new admits by March 12th, 2013. Random audits of admission charts will be done on all admits for the month of March on care plan interventions and all fall risk assessments (include what the audit is for, like completion or inclusion of interventions). A minimum of five 5 charts will be audited per quarter for the subsequent three quarters. 4. DON/Designee will monitor/review audits to ensure compliance. Progress will be reviewed at QA meetings per review schedule.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are 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	F 279		

Plan of Correction Accepted. MKgng RD 3/12/13

RECEIVED
MAR 06 2013
Minnesota Dept of Health
Mankato

AE [illegible] PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Jerry Schneider CFO/Administrator 3/6/13

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

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	245426	A. BUILDING _____ B. WING _____	01/31/2013

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F 279	Continued From page 1 by: Based on observation, interview and document review, the facility failed to develop a comprehensive care plan for 1 of 3 residents (R88) reviewed for accidents. Findings include: Although R88 had been admitted to the facility with a history of falls, the care plan did not address fall prevention. At 11:30 a.m. on 1/30/13, R88 was observed sitting in her wheelchair in the common area watching television and visiting with other residents. The resident was interviewed at that time and stated that she was no longer able to live at home due to frequent falls and requiring help. Record review indicated R88 had been admitted to the facility on 1/8/13 with diagnoses including: hypertension, congestive heart failure and depression. In addition, the record indicated R88 had experienced bradycardia and hypotension the week prior to admission. An initial Minimum Data Set (MDS) dated 1/15/13, indicated R88 had fallen in the last month prior to admission and the fall had caused the resident to complain of pain. A physician's note dated 1/4/13, indicated the resident was at high risk for falls and that he'd consulted with the resident and family to individualize fall prevention interventions for the resident. Another physician's note dated 1/15/13, indicated R88 had experienced several falls since 1/3/13. The note indicated R88 had been hospitalized due to falls and had required medication adjustment, and that the resident had	F 279		

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F 279	Continued From page 2 been discharged to the nursing home for short term monitoring and therapy. In addition, the physician's note indicated R88 had told the physician she could no longer live independently at home. The physical therapist notes indicated the resident had experienced multiple falls prior to admission. R88's record included a fall assessment dated 1/13/13, that indicated the resident had experienced balance problems when standing and walking. The fall assessment indicated the resident had experienced no falls in the last 3 months. The resident's current care plan did not include interventions to prevent falls. The director of nursing (DON) and nurse manager were interviewed at 3:30 p.m. on 1/30/13. They stated that since the fall assessment completed 1/13/13, had failed to capture the resident's history of falls, there had been no care plan interventions developed for prevention of falls.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure interventions	F282	RECEIVED MAR 0 6 2013 Minnesota Dept of Health Mankato 1. Resident #111 has discharged. 2. Licensed staff will examine the skin of all residents in the facility reporting any changes in condition from current observation to the wound nurse.	

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F 282	Continued From page 3 were followed per the plan of care for 1 of 3 (R111) residents who was reviewed for pressure ulcers. Findings include: R111 was admitted to the facility with a history of pressure ulcers and the facility did not consistently implement interventions to prevent further skin breakdown per the plan of care. Review of the progress notes dated 12/5/12, R111 was identified to have a pressure ulcer on the left heel. The progress notes also identified a description of the wound and recommended interventions including: "area measured 1.5 centimeters (cm) by 1.3 cm, beefy red with pink tissue surrounding it." Recommended interventions included: Xeroform treatment dressing, Keen floater placed in bed, heels elevated, heel protectors applied, air mattress on bed and the resident was to be repositioned every 2 hours. In addition, progress notes dated 12/6/13, indicated the facility's wound nurse had been notified of the resident's pressure ulcer. Review of the plan of care identified the resident as having a stage three pressure ulcer on his left heel. Care plan approaches included: encourage vascular boots and heel protectors, air mattress in place on bed, assess condition of the pressure ulcer, facility wound nurse to document weekly, Keen heel floater in bed to off load heels, and turn and reposition every 2 hours. The care plan also identified the resident as being at risk for skin breakdown, related to requiring extensive assistance with bed mobility and a history of pressure ulcers. Review of the nursing assistant	F 282	3. Skin assessments will be completed within 48 hours of admission and with quarterly ARD, annual ARD and with all significant changes in condition. Interventions will be updated in the care plan and communicated on the aid care sheets. The placement of the keen lift heel floater will be reviewed with all care staff. This will be completed by March 12th, 2013. Random audits will be done completed, with 3 charts reviewed each week for one month and then three charts reviewed monthly for 9 months. 4. DON/Designee will monitor/review audits to ensure compliance. Progress will be reviewed at QA meetings per review schedule. RECEIVED MAR 0 6 2013 Minnesota Dept of Health Mankato	

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F 282	Continued From page 4 (NA) care sheet indicated R111 should be turned and repositioned every 2 hours. During observation of R111 on 1/29/13, from 9 a.m. to 11:00 a.m., and again on 1/30/13, from 8:30 a.m. to 10:30 a.m., R111 was observed sitting in the facility lounge with both his feet placed on the floor. R111 was interviewed on 1/31/13 at 9:00 a.m.. R111 stated he was not sure how he'd developed the heel ulcers, but stated that staff do not reposition him every 2 hours like they should. R111 stated that although he prefers to lay on his back, he also wants to do what he can to heal the heel ulcers. Following the interview with R111, nursing assistant (NA)-B was interviewed at 9:18 a.m. on 1/31/13. NA-B confirmed the staff do not reposition R111 every 2 hours. She said she thought the resident repositioned himself in bed, but verified that R111 likes to lay on his back. During an observation of R111 with registered nurse (RN)-B, at 10:00 a.m. on 1/31/13, he was observed laying in bed with a Keen heel floater under his legs. However, both of his heels were resting on the mattress causing pressure to the heels. Observation of the left heel revealed a 0.5 cm by 0.5 cm blackened eschar area with a 1 inch reddened area around the eschar. Observation of the right heel also revealed a reddened area on the outer aspect of the heel measuring 1.5 inches by 1.5 inches of redness. RN-B palpated both heels and stated they were warm and spongy to the touch. RN-B stated staff were not monitoring the left heel any longer because it was healed. She stated treatment to the left heel had been discontinued on 1/30/13.	F 282		

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F 282	Continued From page 5 RN-B confirmed staff should have ensured R111's heels were floated off the mattress and verified the Keen heel floater had not been appropriately placed. RN-B stated it was likely staff had not positioned the resident according to the plan of care, because the resident usually spent his time on a different floor. RN-B said she was going to inform the wound nurse about R111's heels and stated the staff would need to restart treatment to both heels.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor and implement interventions to encourage healing, and to minimize the risk for further pressure ulcer development, for 1 of 3 (R111) residents in the sample reviewed for pressure ulcers. Findings include: R111 was admitted to the facility with a history of pressure ulcers and the facility did not consistently implement interventions to	F314	1. Resident #111 has discharged. 2. Licensed staff will examine the skin of all residents in the facility reporting any changes in condition from current observation to the wound nurse. The neighborhood unit coordinators will ensure the aid care sheets are up to date with all current skin interventions.	

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F 314	Continued From page 6 encouraging healing or prevent further skin breakdown. R111's record was reviewed. The resident was admitted on 3/12/12, with diagnosis that included: peripheral vascular disease, pressure ulcer and acute kidney failure. Review of the progress notes dated 12/5/12, indicated R111 was identified to have a pressure ulcer on the left heel. The progress notes also identified a description of the wound and recommended interventions including: "area measured 1.5 centimeters (cm) by 1.3 cm, beefy red with pink tissue surrounding it." Recommended interventions included: Xeroform treatment dressing, Keen floater placed in bed, heels elevated, heel protectors applied, air mattress on bed and the resident was to be repositioned every 2 hours. In addition, progress notes dated 12/6/13, indicated the facility's wound nurse had been notified of the resident's pressure ulcer. Review of the facility's assessment form, "tissue tolerance" dated 12/5/12, identified R111 as having a history of pressure ulcers on his toes and heels. The form indicated the resident had a Braden (pressure ulcer risk scale) score of "19" (total score of 19 or higher is not considered at risk for skin breakdown). The "tissue tolerance" form indicated staff did not need to proceed due to the resident's low risk. Review of a "skin risk assessment" dated 12/5/12, indicated the resident was at risk for skin breakdown due to dementia, Alzheimer's disease and peripheral vascular disease. The "skin risk assessment" indicated the resident had at least one unhealed pressure ulcer, had been admitted to the facility	F 314	3. Skin assessments will be completed upon admission and with quarterly ARD, annual ARD and with all significant changes in condition. Interventions will be updated in the care plan and communicated on the aid care sheets. The placement of the keen lift heel floater will be reviewed with all care staff. This will be completed by March 12th, 2013. Random audits will be completed, with 3 charts reviewed via weekly skin tool each week for one month and then three charts reviewed monthly for 9 months. 4. DON/Designee will monitor/review audits to ensure compliance. Progress will be reviewed at QA meetings per review schedule. RECEIVED MAR 0 6 2013 Minnesota Dept of Health Mankato	

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F 314	Continued From page 7 with pressure ulcers on his toes, and that the resident required extensive assistance with bed mobility. The resident's most current minimum data set (MDS) assessment dated 12/5/13, indicated that R111 was at risk for skin breakdown and had 1 stage 3 pressure ulcer. The MDS further identified the resident as requiring extensive assistance with bed mobility. Review of the plan of care identified the resident as having a stage three pressure ulcer on his left heel. Care plan approaches included: encourage vascular boots and heel protectors, air mattress in place on bed, assess condition of the pressure ulcer, facility wound nurse to document weekly, Keen heel floater in bed to off load heels, and turn and reposition every 2 hours. The care plan also identified the resident as being at risk for skin breakdown, related to requiring extensive assistance with bed mobility and a history of pressure ulcers. Review of the nursing assistant (NA) care sheet indicated R111 should be turned and repositioned every 2 hours. During observation of R111 on 1/29/13, from 9 a.m. to 11:00 a.m., and again on 1/30/13, from 8:30 a.m. to 10:30 a.m., R111 was observed sitting in the facility lounge with both his feet placed on the floor. R111 was interviewed on 1/31/13 at 9:00 a.m.. R111 stated he was not sure how he'd developed the heel ulcers, but stated that staff do not reposition him every 2 hours like they should. R111 stated that although he prefers to lay on his back, he also wants to do what he can to heal the	F 314		

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F 314	Continued From page 8 heel ulcers. Following the interview with R111, nursing assistant (NA)-B was interviewed at 9:18 a.m. on 1/31/13. NA-B confirmed the staff do not reposition R111 every 2 hours. She said she thought the resident repositioned himself in bed, but verified that R111 likes to lay on his back. Interview with the facility wound nurse registered nurse (RN)-C on 1/31/13 at 9:20 a.m. confirmed that there had been a discrepancy regarding R111's left heel ulcer and that the wound had always been unstageable. RN-C stated that she though that the pressure ulcer may have come from his new shoes but could not confirm this. During an observation of R111 with registered nurse (RN)-B, at 10:00 a.m. on 1/31/13, he was observed laying in bed with a Keen heel floater under his legs. However, both of his heels were resting on the mattress causing pressure to the heels. Observation of the left heel revealed a 0.5 cm by 0.5 cm blackened eschar area with a 1 inch reddened area around the eschar. Observation of the right heel also revealed a reddened area on the outer aspect of the heel measuring 1.5 inches by 1.5 inches of redness. RN-B palpated both heels and stated they were warm and spongy to the touch. RN-B stated staff were not monitoring the left heel any longer because it was healed. She stated treatment to the left heel had been discontinued on 1/30/13. RN-B confirmed staff should have ensured R111's heels were floated off the mattress and verified the Keen heel floater had not been appropriately placed. RN-B stated it was likely staff had not positioned the resident according to the plan of care, because the resident usually spent his time on a different floor. RN-B said she	F 314		

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F 314	Continued From page 9 was going to inform the wound nurse about R111's heels and stated the staff would need to restart treatment to both heels. Further interview with RN-B, revealed she had not been aware of R111 right heel redness and confirmed she had discontinued treatment to the left heal because it was healed. She further included that she was uncertain of what was underneath the resident's remaining eschar on the left heel. Review of the facility's, Pressure Ulcer Policy dated 8/28/12, included procedures for staff to examine residents that are prone to decubitus on every shift for redness, discoloration or blisters over pressure areas that includes the heels, appropriately define and stage pressure ulcers for treatment protocols, and to provide treatment to treat, care for and prevent pressure ulcers.	F 314		
F 329 SS=D	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 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	F329	1. Resident #29 had a lipid panel drawn on 2/7/13. The results were reviewed by the physician with no change in current orders. Resident #5 continues on current dose of Venlafaxin 75 mg bid which was reviewed by provider and dosage continued due to documentation that past reduction attempts have failed. Resident #39 had her Simvastatin discontinued on 1/31/13.	

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F 329	Continued From page 10 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 document review and interview, the facility failed to ensure residents were free from the use of unnecessary medications for 3 of 10 residents (R100, R39 and R5) reviewed for medication use. Findings include: R39 continued to receive a statin medication (Prevastatin) when her family and physician were in agreement that the medication could be discontinued. Review of the resident's medical record revealed a fax (facsimile) communication to the physician dated 11/26/12. The fax note, written by a staff nurse, indicated the continued use of Pravastatin (a cholesterol lowering medication) 80 mg daily, had been reviewed with R39's family at her care conference per the physician's request. The fax note, communicated to the physician that the family was in agreement with discontinuing the medication and asked the physician to write an order to discontinue the medication. As of 1/30/13, the physician had not responded to the fax communication. Further record review revealed the facility staff had not followed up with	F 329	2. Licensed staff will review all residents on Statin medications to ensure lipid panels were obtained within 12 months. All residents on Statin medications will be reviewed on an annual ARD to ensure continued compliance with current/updated lab value. Licensed staff will review all residents on antidepressant medications to ensure gradual dose reductions have been completed, or a dose reduction contraindication form is up to date. All residents on antidepressant medications will be reviewed on annual ARD to ensure continued compliance with GDRs. Licensed staff will provide the neighborhood coordinator with a copy of all faxes sent to the physicians. The neighborhood coordinators will track when faxes have been received back from the physicians	

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F 329	Continued From page 11 the physician when he'd failed to respond to the fax. Licensed practical nurse (LPN)-A was interviewed on 1/30/13 at 10:35 a.m. She verified R39 continued to routinely receive the Pravastatin medication. LPN-A confirmed the physician had not responded to the fax. She also stated that when a physician failed to respond to a fax communication, the nurse would usually fax the request again, or phone the physician to clarify his wishes. LPN-A verified that did not appear to have happened in this case. Laboratory values had not been monitored for R29 who utilized a statin medication (simvastatin) that required blood work monitoring. R29 was admitted to the facility on 10/28/10 with diagnoses including acute kidney failure, diabetes, bipolar disorder, and hyperlipidemia. Physician orders were reviewed from the record. R29 received simvastatin 20 mg daily at bedtime for hyperlipidemia (elevated cholesterol). The medical record revealed no monitoring of the resident's liver function which is recommended on a periodic basis when a statin medication is utilized. During interview with the director of nursing (DON) on 1/31/13 at 2:49 a.m., she confirmed no liver function testing results were available in the R29's record. The DON reported she had contacted the physician to verify that liver function testing had not been completed. The physician indicated she did not feel liver function testing was warranted for monitoring the use of	F 329	All licensed staff will review communication method for ensuring neighborhood coordinators are aware of all the faxes that are being sent to physicians. These will be completed by March 12th, 2013. 3. DON/Designee will monitor/review audits to ensure compliance. Progress will be reviewed at QA meetings per review schedule.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 12 simvastatin but did give an order to have the laboratory studies drawn. R5 routinely took an antidepresant medication (venlafaxin) with any dosage reduction. R5 was admitted to the facility on 11/4/10 with diagnoses including depression and anxiety. The physician orders indicated R5 received venlafaxine 75 mg twice a day for depression. Review of the record revealed that a gradual dose reduction was not attempted or rationale for continued use at the current dose. During an interview with the director of nursing (DON) on 1/31/13 at 2:18 p.m., she confirmed that a gradual dose reduction had not been attempted for R48's venlafaxine, nor was there documented rational to support the continued use of the medication at the current dose.	F 329		
F 356 SS=C	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. - 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	F 356	Koda Living Community (KLC) formerly Cedarview Care Center has and will continue to post the nurse staffing hours. Upon survey, the team pointed out that KLC did not have the actual shift times designated on the posting, but instead had just designated AM shift, PM shift and Night shift. 1. A new facility staffing form was drafted, which designates the actual shift times. The new facility staffing form will be clearly posted and placed in a location that is readily accessible to residents and visitors. *Cont'd on next page*	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245426	A. BUILDING _____ B. WING _____	01/31/2013

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F 356	Continued From page 13 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, interview and document review, the facility failed to post the required information for nursing hours on a daily basis at the beginning of each shift. This had the potential to affect 96 of 96 residents residing in the facility at the time of the survey and any members of the public that wished to view this information. Findings include: During the initial tour of the facility on 1/28/13 at 9:00 a.m., it was observed that the posted nursing hours did not include the actual hours worked per shift for licensed and unlicensed nursing staff responsible for resident care. During an interview with the administrator on 1/31/13, the administrator verified the staff posting failed to identify the hours that comprised the shifts for the actual nursing hours worked.	F 356	2. Scheduling and licensed staff will be reeducated on properly completing the new facility staffing form. Random audits will be done to ensure the actual hours worked by licensed and unlicensed staff is being documented every shift. 3. DON/Designee will monitor/review audits to ensure compliance. Progress will be reviewed at QA meetings per review schedule. 4. This will be completed by March 8, 2012.	

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F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to serve food in a palatable manner including palatable temperatures for 1 of 2 dining rooms in the facility. This had the potential to affect all 34 residents who ate in the first floor dining room. Findings include: During individual interviews, R41, R50, R58, R73, R88 and R160, complained of hot food being cold when served: During interview on 1/29/13 at 9:50 a.m. R41 indicated the hot food served at meals is often cold. Interview with R50 on 1/28/13 at 6:41 p.m, indicated the facility food was not appetizing. Interview with R58 on 1/29/13 at 11:10 a.m., indicated the facility food was not always served hot. Interview with R73 on 1/29/13 at 11:38 a.m. indicated the facility food was not always tasteful or appetizing. Interview with R88 on 1/28/13 at 7:15 p.m., indicated the facility food was often cold and interview with R160 on 1/29/13 at 10:54 a.m., indicated the eggs served for breakfast were often cold. During observations of the breakfast meal service on 1/31/13, it was confirmed food temperatures	F - 364	1. Corrective action was taken by having a new system in place to better track temperatures. The facility has adjusted the training for all new employees and added information on proper food temperatures and handling. Koda Living Community now uses a steam table that has water to keep food warm during service, as opposed to having an electric warmer at the Cedarview Building. Water steam will help keep the food warmer during expanded meal times. 2. This issue was addressed with all current culinary staff. Employees involved in this during the deficiency were reeducated along with the entire staff of the Culinary Department. The staff that will be training new employees will now have a specific training guide they will follow and have to sign off on.	

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F 364	Continued From page 15 were not maintained at appropriate levels to ensure palatability for residents: During observations on 1/31/13, at 7:30 a.m. in the first floor dining room, culinary cook-A was observed to take food temperatures from the steam table prior to serving. The food items were observed to be uncovered. The pasteurized eggs read 130 degrees Fahrenheit (F), the malt-o-meal read 130 degrees F, and the bacon read 90 degrees F. Culinary cook-A, indicated the food temperatures may have dropped after transferring the food to the steam table. Culinary cook-A, rechecked the food temperatures a few minutes later and the temperatures remained unchanged. Culinary cook-A, proceeded to dish the food onto the plates to serve the residents. During this time the surveyor questioned the cook if the food temperatures were appropriate to serve. The cook stated, "I do not have time to worry about the temperatures, because the residents are coming out for breakfast". The dietary director intervened and instructed culinary cook-A not to serve the meal until the food temperatures were at appropriate levels. The dietary director proceeded to stir the food items on the steam table and covered the food with extra tin foil. After 5 minutes, the dietary manager re-checked the food temperatures. The temp of the eggs reached 165 degrees F, the malt-o-meal 135 degrees F and the bacon read 145 degrees F. Interview with culinary cook-A on 1/13/13 at 7:40 a.m., indicated she was aware of the proper food temperatures. She further indicated that the temperature of the eggs should have read 165 degrees F, the malt-o-meal at 180 degrees F	F 364	3. Daily tracking forms were revamped to enable better tracking of temperatures. Training for new hires and yearly training for all culinary staff will be instituted as a refresher on proper temperatures and food handling. In addition, with the Koda building having neighborhood kitchens and steam tables on each of these neighborhoods, will allow for enhanced food quality and areas to re-heat and prepare other meal choices during meal times. 4. Performance will be monitored by the new tracking form being filled out at each meal. This tracks temperatures once foods get to the neighborhood kitchens and temperatures when they are done with service. This report gets turned in daily to the Culinary Director along with the temperatures being taken in the kitchen when the food is done cooking.	

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F 364	Continued From page 16 and the bacon at 175 degrees F. Interview with the dietary director on 1/31/13 at 7:45 a.m. confirmed the cook should not serve the breakfast meal with inadequate temperatures. She stated the staff are aware and have been trained regarding appropriate food temperatures. The dietary director also verified that the steam tables should have been covered to maintain the temperature of food for serving. Review of the facility policy, Maintaining Proper Food Temp During Food Service indicated foods to be served would be maintained at proper hot and cold temperatures prior to and during service to assure food quality as well as food safety. The policy further stated the temperature of potentially hazardous hot foods will be no less than 150 degrees F during tray assembly and no less than 140 degrees F when served to the resident from the steam table. The policy also indicated the steam table wells were to be completely covered with steam table pans thus not allowing heat to escape.	F 364	5. On 1/31/13 after breakfast temperatures were addressed with the surveyor, Cook-A was reeducated abou how to properly take food temperatures and discussion took plac on the correct temperatures all food should be at. The next day 2/1/13 employees were reeducated on the Koda policy regarding proper handling of food items including hot items, cold items and proper temperatures in the steam tables. On 2/9/13 a mandatory staff meeting was held that specifically addressed the survey process and F-364. The staff watched a video on a mock survey and everything that is covered during the process. This allowed the Culinary Staff a better understanding of exactly what is involved when a SNF goes through the survey process. In addition, temperature danger zone was re-addressed with all culinary staff to give them a better awareness and educatec them on the times to take temperatures of their food as outlined in the culinary policy. 6. The Culinary Director/Designee will be responsible for monitoring. Completio took place on 2/9/13.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		

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F 428	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure the pharmacist recognized and reported medication irregularities for 3 of 10 residents (R100, R39, and R5) reviewed for medication use. Findings include: R39 continued to receive a statin medication when her family and physician were in agreement that the medication could be discontinued. The pharmacist failed to report the continued use of the medication to the director of nursing. Review of the resident's medical record revealed a fax communication to the physician dated 11/26/12. The note written by a staff nurse stated the continued use of Pravastatin (a cholesterol lowering medication) 80 mg daily, had been reviewed with R39's family at her care conference per the physician's request. The note communicated to the physician, the family was in agreement with discontinuing the medication and asked the physician to write an order to discontinue the medication. The fax communication was never responded to by the physician. Further record review revealed the facility staff had not followed up with the physician when he failed to respond to the fax. LPN-A was interviewed on 1/30/13 at 10:35 a.m. She verified R39 remained on the medication. She confirmed the physician had not responded to the fax. She stated if there was no response to fax communication, the facility usually sent the information again or phoned the physician to	F 428	F 428 1. Resident #29 had a lipid panel drawn on 2/7/13. The results were reviewed by the physician with no change in current orders. Resident #5 continues on current dose of Venlafaxin 75 mg bid which was reviewed by provider and dosage continued due to documentation that past reduction attempts have failed. Resident #39 had her Simvastatin discontinued on 1/31/13. 2. Licensed staff will review all residents on Statin medications to ensure lipid panels were obtained within 12 months. All residents on Statin medications will be reviewed on an annual ARD to ensure continued compliance with current/updated lab value. Licensed staff will review all residents on antidepressant medications to ensure gradual dose reductions have been completed, or a dose reduction	

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F 428	Continued From page 18 clarify his wishes. She stated she would send the information to the physician again for response. Review of the pharmacist reports, including December and January, revealed no recommendation related to the continued use of the statin medication by R39. This was confirmed by the director of nursing on 1/31/13 at 2:10 p.m. The pharmacy consulting firm was contacted by phone but failed to return the call to the surveyor. Laboratory values had not been monitored for R29 who utilized a statin medication that required blood work monitoring. R29 was admitted to the facility on 10/28/10 with diagnoses including but not limited to acute kidney failure, diabetes, bipolar disorder, and hyperlipidemia. R29 received simvastatin 20 mg daily at bedtime for hyperlipidemia. Review of the medical record revealed no monitoring of the resident's liver function which is recommended on a periodic basis when that medication is utilized. During interview with the director of nursing (DON) on 1/31/13 at 2:49 a.m., she confirmed no liver function testing results were available in the resident's record. The pharmacist had made no recommendations regarding the liver function test either. R5 was admitted to the facility on 11/4/10 with diagnoses including depression and anxiety.	F 428	contraindication form is up to date. All residents on antidepressant medications will be reviewed on annual ARD to ensure continued compliance with GDRs. Licensed staff will provide the neighborhood coordinator with a copy of all faxes sent to the physicians. The neighborhood coordinators will track when faxes have been received back from the physicians All licensed staff will review communication method for ensuring neighborhood coordinators are aware of all the faxes that are being sent to physicians. These will be completed by March 12th, 2013.	

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F 428	Continued From page 19 R5 received venlafaxine 75 mg twice a day for depression. Review of the record revealed that a gradual dose reduction was not attempted or rationale for continued use at the current dose. During an interview with the director of nursing (DON) on 1/31/13 at 2:18 p.m., she confirmed that a gradual dose reduction had not been attempted on R48's venlafaxine or rational to support continued use at the current dose. The pharmacist had made no recommendations regarding a gradual dose reduction either.	F 428	The Consultant Pharmacist will be advised and requested to review these guidelines in the resident records. 3. DON/Designee will monitor/review audits to ensure compliance. Progress will be reviewed at QA meetings per review schedule.	

F542602)

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

PRINTED: 02/15/2013
FORM APPROVED
OMB NO. 0938-0391

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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 CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF A ACCEPTABLE POC, AN ON-SITE REVISIT 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 Masrahl Division. At the time of this survey, Steele County Communities For A Lifetime Inc. was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	POC ok FB 3-4-13 RECEIVED MAR 4 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Dec: 3-12-13

EXIT: 1-31-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Terry Schneider	CEO/Administrator	3/2/13

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

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K 000	Continued From page 1	K 000		

By email to:
Barbara.Lundberg@state.mn.us and
Marian.Whitney@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Steele County Communities For A Lifetime Inc. is a 2-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1971 and was determined to be of Type II(222) construction. In 1973, addition was constructed and was determined to be of Type II(222) construction. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building.

The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection in the corridors, spaces open to the corridors, and all residents sleep rooms that is monitored for automatic fire department notification.

The facility has a capacity of 108 beds and had a

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K 000	Continued From page 2 census of 94 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 94 residents. Findings include: On facility tour between 7:30 AM and 9:30 AM on 01/29/2013, the review of the fire drill documentation for the past 12 months (February 2012 to January 2013) revealed the drills for the the following shifts were completed but did not sufficiently vary the times that the drills were	K 050	1. Fire drills will be conducted during the varied times on each shift as designated and instructed by the Fire Marshall and State Life Safety Code. Each drill on each shift will be held at least with a two hour difference from the previous quarter's drill on that shift. In addition, these drills will be held on varied days of the week. All drills will be schedule and monitored by the Maintenance Department. 2. This will be completed by 3/12/13. 3. The person responsible for correction and monitoring this will be the Environmental Supervisor/Designee.	

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K 050	Continued From page 3 conducted: Day - 1300, 1000, 1300 and 1000 hours Evening - 1830, 1630, 1800 and 1630 hours Night - 2300, 0100, 2300 and 0100 hours This deficient practice was confirmed by the Facility Maintenance Director (KW) at the time of discovery.	K 050		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test the emergency generators in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6-4.1. The deficient practice could affect all 94 residents. Findings include: On facility tour between 7:30 AM and 9:30 AM on 01/29/2013, the documentation review of the weekly inspection logs (January 2012 to January 2013) for the diesel emergency generator	K 144	1. It is alleged that the facility missed 5 inspections during the year; however, they actually did occur. The facility logs all inspections into an internet Tels system and then prints that for the facilities log book. The deficiency occurred due to personnel failing to log the inspection into the Tels system and printing for the facility records. 2. Maintenance staff were re-educated on the requirement that inspections must be logged into the facility records in a timely fashion. 3. The Environmental Supervisor/Designee will be responsible to monitor this correction. 4. Completion Date is 3/12/13.	

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	245426	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/29/2013

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STEELE COUNTY COMMUNITIES FOR A LIFETIME INC	1409 SOUTH CEDAR AVENUE 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 144	Continued From page 4 revealed that a weekly operational inspections were missed for the weeks of 03/11, 06/25, 07/02, 09/02 and 09/11/2012. This deficient practice was confirmed by the Facility Maintenance Director (KW) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 144		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 5815

February 15, 2013

Ms. Terry Schneider, Administrator
Steele County Communities For A Lifetime Inc
1409 South Cedar Avenue
Owatonna, Minnesota 55060

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5426023

Dear Ms. Schneider:

The above facility was surveyed on January 28, 2013 through January 31, 2013 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, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 12 Civic Center Plaza, Suite 2105, Mankato, Minnesota 56001-7789. 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 me.

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,

Maria King, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (507) 344-2716 Fax: (507) 344-2723

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00644	A. BUILDING _____ B. WING _____	01/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEELE COUNTY COMMUNITIES FOR A LIFET	1409 SOUTH CEDAR AVENUE OWATONNA, MN 55060

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On January 28, 29, 30 and 31 2013, surveyors of this Department's staff, visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	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.	

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2 000	Continued From page 1 Certification Program; Mankato Place, 12 Civic Center Plaza #2105, Mankato, MN 56001.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced	2 560		

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2 560	Continued From page 2 by: Based on observation, interview and document review, the facility failed to develop a comprehensive care plan for 1 of 3 residents (R88) reviewed for accidents. Findings include: Although R88 had been admitted to the facility with a history of falls, the care plan did not address fall prevention. At 11:30 a.m. on 1/30/13, R88 was observed sitting in her wheelchair in the common area watching television and visiting with other residents. The resident was interviewed at that time and stated that she was no longer able to live at home due to frequent falls and requiring help. Record review indicated R88 had been admitted to the facility on 1/8/13 with diagnoses including: hypertension, congestive heart failure and depression. In addition, the record indicated R88 had experienced bradycardia and hypotension the week prior to admission. An initial Minimum Data Set (MDS) dated 1/15/13, indicated R88 had fallen in the last month prior to admission and the fall had caused the resident to complain of pain. A physician's note dated 1/4/13, indicated the resident was at high risk for falls and that he'd consulted with the resident and family to individualize fall prevention interventions for the resident. Another physician's note dated 1/15/13, indicated R88 had experienced several falls since 1/3/13. The note indicated R88 had been hospitalized due to falls and had required medication adjustment, and that the resident had been discharged to the nursing home for short term monitoring and therapy. In addition, the	2 560		

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2 560	Continued From page 3 physician's note indicated R88 had told the physician she could no longer live independently at home. The physical therapist notes indicated the resident had experienced multiple falls prior to admission. R88's record included a fall assessment dated 1/13/13, that indicated the resident had experienced balance problems when standing and walking. The fall assessment indicated the resident had experienced no falls in the last 3 months. The resident's current care plan did not include interventions to prevent falls. The director of nursing (DON) and nurse manager were interviewed at 3:30 p.m. on 1/30/13. They stated that since the fall assessment completed 1/13/13, had failed to capture the resident's history of falls, there had been no care plan interventions developed for prevention of falls. SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could direct staff to develop a care plan to include appropriate interventions for all identified care needs. A monitoring program could be established in order to assure ongoing and effective care plan interventions in response to resident care needs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the	2 565		

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2 565	Continued From page 4 care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure interventions were followed per the plan of care for 1 of 3 (R111) residents who was reviewed for pressure ulcers. Findings include: R111 was admitted to the facility with a history of pressure ulcers and the facility did not consistently implement interventions to prevent further skin breakdown per the plan of care. Review of the progress notes dated 12/5/12, R111 was identified to have a pressure ulcer on the left heel. The progress notes also identified a description of the wound and recommended interventions including: "area measured 1.5 centimeters (cm) by 1.3 cm, beefy red with pink tissue surrounding it." Recommended interventions included: Xeroform treatment dressing, Keen floater placed in bed, heels elevated, heel protectors applied, air mattress on bed and the resident was to be repositioned every 2 hours. In addition, progress notes dated 12/6/13, indicated the facility's wound nurse had been notified of the resident's pressure ulcer. Review of the plan of care identified the resident as having a stage three pressure ulcer on his left heel. Care plan approaches included: encourage vascular boots and heel protectors, air mattress in place on bed, assess condition of the pressure	2 565		

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2 565	Continued From page 5 ulcer, facility wound nurse to document weekly, Keen heel floater in bed to off load heels, and turn and reposition every 2 hours. The care plan also identified the resident as being at risk for skin breakdown, related to requiring extensive assistance with bed mobility and a history of pressure ulcers. Review of the nursing assistant (NA) care sheet indicated R111 should be turned and repositioned every 2 hours. During observation of R111 on 1/29/13, from 9 a.m. to 11:00 a.m., and again on 1/30/13, from 8:30 a.m. to 10:30 a.m., R111 was observed sitting in the facility lounge with both his feet placed on the floor. R111 was interviewed on 1/31/13 at 9:00 a.m.. R111 stated he was not sure how he'd developed the heel ulcers, but stated that staff do not reposition him every 2 hours like they should. R111 stated that although he prefers to lay on his back, he also wants to do what he can to heal the heel ulcers. Following the interview with R111, nursing assistant (NA)-B was interviewed at 9:18 a.m. on 1/31/13. NA-B confirmed the staff do not reposition R111 every 2 hours. She said she thought the resident repositioned himself in bed, but verified that R111 likes to lay on his back. During an observation of R111 with registered nurse (RN)-B, at 10:00 a.m. on 1/31/13, he was observed laying in bed with a Keen heel floater under his legs. However, both of his heels were resting on the mattress causing pressure to the heels. Observation of the left heel revealed a 0.5 cm by 0.5 cm blackened eschar area with a 1 inch reddened area around the eschar. Observation of the right heel also revealed a reddened area on the outer aspect of the heel measuring 1.5 inches by 1.5 inches of redness.	2 565		

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2 565	Continued From page 6 RN-B palpated both heels and stated they were warm and spongy to the touch. RN-B stated staff were not monitoring the left heel any longer because it was healed. She stated treatment to the left heel had been discontinued on 1/30/13. RN-B confirmed staff should have ensured R111's heels were floated off the mattress and verified the Keen heel floater had not been appropriately placed. RN-B stated it was likely staff had not positioned the resident according to the plan of care, because the resident usually spent his time on a different floor. RN-B said she was going to inform the wound nurse about R111's heels and stated the staff would need to restart treatment to both heels. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and	2 900		

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2 900	Continued From page 7 B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor and implement interventions to encourage healing, and to minimize the risk for further pressure ulcer development, for 1 of 3 (R111) residents in the sample reviewed for pressure ulcers. Findings include: R111 was admitted to the facility with a history of pressure ulcers and the facility did not consistently implement interventions to encouraging healing or prevent further skin breakdown. R111's record was reviewed. The resident was admitted on 3/12/12, with diagnosis that included: peripheral vascular disease, pressure ulcer and acute kidney failure. Review of the progress notes dated 12/5/12, indicated R111 was identified to have a pressure ulcer on the left heel. The progress notes also identified a description of the wound and recommended interventions including: "area measured 1.5 centimeters (cm) by 1.3 cm, beefy red with pink tissue surrounding it." Recommended interventions included: Xeroform treatment dressing, Keen floater placed in bed, heels elevated, heel protectors applied, air mattress on bed and the resident was to be repositioned every 2 hours. In addition, progress notes dated 12/6/13, indicated the facility's wound	2 900		

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2 900	Continued From page 8 nurse had been notified of the resident's pressure ulcer. Review of the facility's assessment form, "tissue tolerance" dated 12/5/12, identified R111 as having a history of pressure ulcers on his toes and heels. The form indicated the resident had a Braden (pressure ulcer risk scale) score of "19" (total score of 19 or higher is not considered at risk for skin breakdown). The "tissue tolerance" form indicated staff did not need to proceed due to the resident's low risk. Review of a "skin risk assessment" dated 12/5/12, indicated the resident was at risk for skin breakdown due to dementia, Alzheimer's disease and peripheral vascular disease. The "skin risk assessment" indicated the resident had at least one unhealed pressure ulcer, had been admitted to the facility with pressure ulcers on his toes, and that the resident required extensive assistance with bed mobility. The resident's most current minimum data set (MDS) assessment dated 12/5/13, indicated that R111 was at risk for skin breakdown and had 1 stage 3 pressure ulcer. The MDS further identified the resident as requiring extensive assistance with bed mobility. Review of the plan of care identified the resident as having a stage three pressure ulcer on his left heel. Care plan approaches included: encourage vascular boots and heel protectors, air mattress in place on bed, assess condition of the pressure ulcer, facility wound nurse to document weekly, Keen heel floater in bed to off load heels, and turn and reposition every 2 hours. The care plan also identified the resident as being at risk for skin breakdown, related to requiring extensive assistance with bed mobility and a history of	2 900		

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2 900	Continued From page 9 pressure ulcers. Review of the nursing assistant (NA) care sheet indicated R111 should be turned and repositioned every 2 hours. During observation of R111 on 1/29/13, from 9 a.m. to 11:00 a.m., and again on 1/30/13, from 8:30 a.m. to 10:30 a.m., R111 was observed sitting in the facility lounge with both his feet placed on the floor. R111 was interviewed on 1/31/13 at 9:00 a.m.. R111 stated he was not sure how he'd developed the heel ulcers, but stated that staff do not reposition him every 2 hours like they should. R111 stated that although he prefers to lay on his back, he also wants to do what he can to heal the heel ulcers. Following the interview with R111, nursing assistant (NA)-B was interviewed at 9:18 a.m. on 1/31/13. NA-B confirmed the staff do not reposition R111 every 2 hours. She said she thought the resident repositioned himself in bed, but verified that R111 likes to lay on his back. Interview with the facility wound nurse registered nurse (RN)-C on 1/31/13 at 9:20 a.m. confirmed that there had been a discrepancy regarding R111's left heel ulcer and that the wound had always been unstageable. RN-C stated that she though that the pressure ulcer may have come from his new shoes but could not confirm this. During an observation of R111 with registered nurse (RN)-B, at 10:00 a.m. on 1/31/13, he was observed laying in bed with a Keen heel floater under his legs. However, both of his heels were resting on the mattress causing pressure to the heels. Observation of the left heel revealed a 0.5 cm by 0.5 cm blackened eschar area with a 1 inch reddened area around the eschar. Observation of the right heel also revealed a	2 900		

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2 900	Continued From page 10 reddened area on the outer aspect of the heel measuring 1.5 inches by 1.5 inches of redness. RN-B palpated both heels and stated they were warm and spongy to the touch. RN-B stated staff were not monitoring the left heel any longer because it was healed. She stated treatment to the left heel had been discontinued on 1/30/13. RN-B confirmed staff should have ensured R111's heels were floated off the mattress and verified the Keen heel floater had not been appropriately placed. RN-B stated it was likely staff had not positioned the resident according to the plan of care, because the resident usually spent his time on a different floor. RN-B said she was going to inform the wound nurse about R111's heels and stated the staff would need to restart treatment to both heels. Further interview with RN-B, revealed she had not been aware of R111 right heel redness and confirmed she had discontinued treatment to the left heal because it was healed. She further included that she was uncertain of what was underneath the resident's remaining eschar on the left heel. Review of the facility's, Pressure Ulcer Policy dated 8/28/12, included procedures for staff to examine residents that are prone to decubitus on every shift for redness, discoloration or blisters over pressure areas that includes the heels, appropriately define and stage pressure ulcers for treatment protocols, and to provide treatment to treat, care for and prevent pressure ulcers SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review policies and procedures regarding care for residents at risk or with pressure ulcers, educate staff on pressure ulcers protocols and develop a monitoring system to ensure compliance.	2 900		

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2 900	Continued From page 11 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: F371 A SUGGESTED METHOD FOR CORRECTION: The administrator and/or dietician could review and revise food service policies and procedures to assure that food is served in a sanitary manner. Staff could be trained as necessary. The Certified Dietary Manager could monitor the service of food on a periodic basis. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21015		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is	21530		

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STEELE COUNTY COMMUNITIES FOR A LIFET	1409 SOUTH CEDAR AVENUE OWATONNA, MN 55060

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21530	Continued From page 12 available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to ensure the pharmacist recognized and reported medication irregularities for 3 of 10 residents (R100, R39, and R5) reviewed for medication use. Findings include:	21530		

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21530	Continued From page 13 R39 continued to receive a statin medication when her family and physician were in agreement that the medication could be discontinued. The pharmacist failed to report the continued use of the medication to the director of nursing. Review of the resident's medical record revealed a fax communication to the physician dated 11/26/12. The note written by a staff nurse stated the continued use of Pravastatin (a cholesterol lowering medication) 80 mg daily, had been reviewed with R39's family at her care conference per the physician's request. The note communicated to the physician, the family was in agreement with discontinuing the medication and asked the physician to write an order to discontinue the medication. The fax communication was never responded to by the physician. Further record review revealed the facility staff had not followed up with the physician when he failed to respond to the fax. LPN-A was interviewed on 1/30/13 at 10:35 a.m. She verified R39 remained on the medication. She confirmed the physician had not responded to the fax. She stated if there was no response to fax communication, the facility usually sent the information again or phoned the physician to clarify his wishes. She stated she would send the information to the physician again for response. Review of the pharmacist reports, including December and January, revealed no recommendation related to the continued use of the statin medication by R39. This was confirmed by the director of nursing on 1/31/13 at 2:10 p.m. The pharmacy consulting firm was contacted by phone but failed to return the call to the surveyor. Laboratory values had not been monitored for R29 who utilized a statin medication that required	21530		

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21530	Continued From page 14 blood work monitoring. R29 was admitted to the facility on 10/28/10 with diagnoses including but not limited to acute kidney failure, diabetes, bipolar disorder, and hyperlipidemia. R29 received simvastatin 20 mg daily at bedtime for hyperlipidemia. Review of the medical record revealed no monitoring of the resident's liver function which is recommended on a periodic basis when that medication is utilized. During interview with the director of nursing (DON) on 1/31/13 at 2:49 a.m., she confirmed no liver function testing results were available in the resident's record. The pharmacist had made no recommendations regarding the liver function test either. R5 was admitted to the facility on 11/4/10 with diagnoses including depression and anxiety. R5 received venlafaxine 75 mg twice a day for depression. Review of the record revealed that a gradual dose reduction was not attempted or rationale for continued use at the current dose. During an interview with the director of nursing (DON) on 1/31/13 at 2:18 p.m., she confirmed that a gradual dose reduction had not been attempted on R48's venlafaxine or rational to support continued use at the current dose. The pharmacist had made no recommendations regarding a gradual dose reduction either. SUGGESTED METHOD FOR CORRECTION: The administrator, director of nursing and consulting pharmacist could review and revise policies and procedures for proper monitoring of	21530		

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21530	Continued From page 15 medication usage. Staff could be educated as necessary. The director of nursing or designee could monitor medications on a regular basis to ensure compliance with state and federal regulations. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21530		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to ensure residents were free from	21540		

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21540	Continued From page 16 the use of unnecessary medications for 3 of 10 residents (R100, R39 and R5) reviewed for medication use. Findings include: R39 continued to receive a statin medication (Prevastatin) when her family and physician were in agreement that the medication could be discontinued. Review of the resident's medical record revealed a fax (facsimile) communication to the physician dated 11/26/12. The fax note, written by a staff nurse, indicated the continued use of Pravastatin (a cholesterol lowering medication) 80 mg daily, had been reviewed with R39's family at her care conference per the physician's request. The fax note, communicated to the physician that the family was in agreement with discontinuing the medication and asked the physician to write an order to discontinue the medication. As of 1/30/13, the physician had not responded to the fax communication. Further record review revealed the facility staff had not followed up with the physician when he'd failed to respond to the fax. Licensed practical nurse (LPN)-A was interviewed on 1/30/13 at 10:35 a.m. She verified R39 continued to routinely receive the Pravastatin medication. LPN-A confirmed the physician had not responded to the fax. She also stated that when a physician failed to respond to a fax communication, the nurse would usually fax the request again, or phone the physician to clarify his wishes. LPN-A verified that did not appear to have happened in this case. Laboratory values had not been monitored for	21540		

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21540	Continued From page 17 R29 who utilized a statin medication (simvastatin) that required blood work monitoring. R29 was admitted to the facility on 10/28/10 with diagnoses including acute kidney failure, diabetes, bipolar disorder, and hyperlipidemia. Physician orders were reviewed from the record. R29 received simvastatin 20 mg daily at bedtime for hyperlipidemia (elevated cholesterol). The medical record revealed no monitoring of the resident's liver function which is recommended on a periodic basis when a statin medication is utilized. During interview with the director of nursing (DON) on 1/31/13 at 2:49 a.m., she confirmed no liver function testing results were available in the R29's record. The DON reported she had contacted the physician to verify that liver function testing had not been completed. The physician indicated she did not feel liver function testing was warranted for monitoring the use of simvastatin but did give an order to have the laboratory studies drawn. R5 routinely took an antidepresant medication (venlafaxin) with any dosage reduction. R5 was admitted to the facility on 11/4/10 with diagnoses including depression and anxiety. The physician orders indicated R5 received venlafaxine 75 mg twice a day for depression. Review of the record revealed that a gradual dose reduction was not attempted or rationale for continued use at the current dose. During an interview with the director of nursing (DON) on 1/31/13 at 2:18 p.m., she confirmed that a gradual dose reduction had not been attempted for R48's venlafaxine, nor was there	21540		

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21540	Continued From page 18 documented rational to support the continued use of the medication at the current dose. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could review the need for medication monitoring with the licensed staff including the State and Federal regulations. She could randomly audit resident medication orders to ensure that medications were utilized in accordance with accepted standards, and to ensure medications were monitored for potential adverse effects. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		