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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: FQ8D
Facility ID: 00681

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245440**

2. STATE VENDOR OR MEDICAID NO. (L2) **765240200**

3. NAME AND ADDRESS OF FACILITY
(L3) **JANESVILLE NURSING HOME**
(L4) **102 EAST NORTH STREET**
(L5) **JANESVILLE, MN** (L6) **56048**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **03/02/2016** (L34)

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**

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

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

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

12.Total Facility Beds **40** (L18)

13.Total Certified Beds **40** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	40			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 3/9/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/09/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **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. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245440

March 8, 2016

Mr. R. Peter Madel III, Administrator
Janesville Nursing Home
102 East North Street
Janesville, MN 56048

Dear Mr. Madel III:

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 February 23, 2016 the above facility is certified for:

40 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 40 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

An equal opportunity employer

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered
March 8, 2016

Mr. R. Peter Madel III, Administrator
Janesville Nursing Home
102 East North Street
Janesville, MN 56048

RE: Project Number S5440026

Dear Mr. Madel III:

On January 26, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 14, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On March 2, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 14, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 23, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 14, 2016, effective February 23, 2016 and therefore remedies outlined in our letter to you dated January 26, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245440		3/2/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	Correction Completed 02/23/2016	ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 02/23/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	KS/kfd	3/8/2016	03048	3/2/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	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
1/14/2016	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
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Facility ID: 00681

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(L3) **JANESVILLE NURSING HOME**
(L4) **102 EAST NORTH STREET**
(L5) **JANESVILLE, MN** (L6) **56048**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY **01/14/2016** (L34)
8. ACCREDITATION STATUS: __ (L10)
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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)
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And/Or Approved Waivers Of The Following Requirements:
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__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B** (L12)

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	40			
(L37)	(L38)	(L39)	(L42)	(L43)

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1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE Date :
Carol Bode, HFE NE II 2/8/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/08/2016 (L20)

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

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____ 2. Facility is not Eligible
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02/01/1987
(L24)

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(L41)

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25. LTC EXTENSION DATE:
(L27)

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(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
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02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted
January 26, 2016

Mr. R. Peter Madel III, Administrator
Janesville Nursing Home
102 East North Street
Janesville, MN 56048

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5440026

Dear Mr. Madel III:

The above facility was surveyed on January 11, 2016 through January 14, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the

correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Kathryn Serie, Supervisor at 507-476-4233.

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

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

Please feel free to call me with any questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING ______ B. WING ______	01/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		2/23/16

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

Electronically Signed — 02/02/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING ______ B. WING ______	01/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	**102 EAST NORTH STREET JANESVILLE, MN 56048**

(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 280	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to revise the care plan for 1 of 3 residents (R7) to reflect a change in mobility needs for locomotion reviewed for positioning. Findings included: During an observation on 1/11/2016, at 3:40 p.m. R7 was awake and sitting in Rock and Go wheel chair in her room. R7's feet were dangling approximately four inches from the floor. The chair did not have footrests for leg support on at this time. During an observation on 1/13/16, at 7:39 a.m. staff pushed R7 from dining room to her room in Rock and Go wheel chair. R7's feet dangled approximately four inches from the floor, no footrests observed on the chair. During an interview at 8:17 a.m. nursing assistant (NA)-A indicated staff had not been using the foot pedals. NA-A explained R7 sometimes moved herself around. NA-A was asked how R7 moved around when her feet could not touch the floor, NA-A responded by explaining R7 had varying levels of energy. NA-A further explained nursing changed the chair to the Rock and Go because R7 had been sick and could not sit up in a standard wheelchair. NA-A stated R7 used to wheel herself all over. During an observation on 1/13/16, at 8:34 a.m. staff pushed R7 down the hallway with footrests on the wheelchair. During an observation on 1/13/16, at 11:42 a.m. R7 attempted to wheel self out of her room by using her hands on the wheels. R7 had a difficult time maneuvering the chair through her doorway. Licensed practical nurse (LPN)-A assisted R7 out	F 280	We disagree with the surveyor's findings in this area. We find them to be merely observational findings that in no way rise to the level of a deficient practice. However, in the spirit of cooperation and to insure that we are providing the highest level of patient care, we have taken the following steps. The Director of Nursing and MDS nurse have reviewed the policies and procedures for care plan revisions. They reviewed care plans to make sure that they are accurate and up-to-date. The DON and MDS nurse have met individually with licensed staff, to review the need for the care plans to accurately reflect the care that is being provided. The MDS nurse will perform audits of Care Plans and will report her findings to the Quality Assurance Committee at its quarterly meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING ______ B. WING ______	01/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	**102 EAST NORTH STREET JANESVILLE, MN 56048**

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F 280	Continued From page 2 of the room and then encouraged R7 to continue to self-propel chair and provided instructions on how to move the chair with her arms. R7 was able to move the chair with instruction and with difficulty; the chair moved mere inches at a time. Total distance that R7 was able to move was approximately fifteen feet with assistance. R7's quarterly Minimum Data Set (MDS) dated 9/11/15 prior to the illness identified R7 had severe cognitive impairment with a Brief Interview for Mental Status Score (BIMS) of three. The assessment indicated R7 required extensive assist from one staff member for locomotion on and off the unit, had functional limitations in range of motion for both upper and lower extremities, and was unsteady with transfers. The MDS dated 12/11/15 showed a decline in R7's self-performance for locomotion; R7 was now dependent on one staff member for locomotion. R7's electronic care plan provided by the facility on 1/14/15 did not reflect the dependent level of assistance for locomotion indicated on the 12/11/15 assessment. The care plan indicated R7 did not ambulate, however, was independent with locomotion on and off the nursing units, but required staff to assist her to scheduled destinations. The care plan directed staff to encourage independence and maintain optimal level of functioning. The care plan further informed staff, "Enjoys wheeling around the facility on a daily basis." R7's CNA Assignment Card was consistent with the care plan for locomotion on and off the unit. R7's nursing progress notes were reviewed from 11/1/15 through 1/14/16. -11/8/15 nursing progress note included, "Resident leaning over in her wheelchair, repositioned resident in a reclining chair for comfort and to prevent injury. Resident has no c/o	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING ______ B. WING ______	01/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 280	Continued From page 3 [complaints of] different chair, trys [sig] to wheel self as she did in old chair but will ask staff to take her to her room." -11/17/15 nursing progress note assessment included, "Move off the unit: Requires one aide assist to move about off the unit. Is directed and or/enc. [encouraged] and occasionally given some physical assist to move about off unit. Devices: primary mode of locomotion is with wheelchair. Is wheeled by others. Infrequently his/her own wheelchair. Move on Unit: Requires one aide assist to move about the unit. Directed and/or encouraged with some occasional physical assist to move about the unit." -12/15/15 nursing progress note assessment included, "Move on unit: Requires one aide assist to move about the unit. Directed and/or encouraged with some occasional physical assist to move about the unit. Is able propel self short distances." The care plan did not reflect revision related to R7's decline in locomotion or change in wheel chair. During an interview on 1/13/16, director of nursing (DON) indicated awareness the residents feet were dangling and had alerted maintenance for possible chair adjustments. An interview on 1/13/16, at 11:44 a.m. with occupational therapist (OT)-A and certified occupational therapist assistant (COTA)-A was conducted. COTA-A indicated nursing had not requested a therapy evaluation for positioning and stated R7 last completed therapy in August of 2014 for functional transfer training and upper body strengthening. OT-A explained residents should be referred for positioning when there is an increased need for assistant from what was previously provided, a change in positioning, with a change in condition, and when there is skin	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(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 280	Continued From page 4 breakdown. OT-A indicated ideally nursing staff would communicate wheelchairs are changed out. OT-A stated from a therapy stand point, "we would never recommend a Rock and Go wheel chair for any reason." COTA-A indicated screening was performed quarterly screens on everyone in the building to see if there is a need, however did not have a quarterly screen on file. Facility policy Weekly Charting and Care Plan Review Policy last reviewed 9/13 included, "Week 3 ADL [activities of daily living} charting-Document in Nurses Notes-Review ADL Care Plan Problem.", and "update care plans when appropriate with scheduled weekly charting and daily as changes occur with residents."	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide proper positioning in a Rock and Go wheel chair and failed to evaluate the identified decline in mobility after an acute illness 1 of 3 (R7) reviewed for positioning. Findings include:	F 309	We respectfully disagree with the surveyor's findings in this area. We find them to merely be observational findings that in no way rise to the level of a deficient practice. However, in the spirit of cooperation, we have taken the following steps.	2/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING ______ B. WING ______	01/14/2016

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F 309	Continued From page 5 R7 had an acute illness in November 2015. During that time, the facility changed R7's standard wheel chair to a Rock and Go wheel chair (type of wheel chair that has a high back, large wheels, and rocks back and forth with movement.) The record reflects a decline in mobility during this time. The record lacked evidence the facility comprehensively assess the identified decline in mobility to restore previous level functioning or prevent further decline. During an observation on 1/11/2016, at 3:40 p.m. R7 was awake and sitting in Rock and Go wheel chair in her room. R7's feet were dangling approximately four inches from the floor. The chair did not have footrests for leg support on at this time. During an observation on 1/13/16, at 7:39 a.m. staff pushed R7 from dining room to her room in Rock and Go wheel chair. R7's feet dangled approximately four inches from the floor, no footrests observed on the chair. During an interview at 8:17 a.m. nursing assistant (NA)-A indicated staff had not been using the foot pedals. NA-A explained R7 sometimes moved herself around. NA-A was asked how R7 moved around when her feet could not touch the floor, NA-A responded by explaining R7 had varying levels of energy. NA-A further explained nursing changed the chair to the Rock and Go because R7 had been sick and could not sit up in a standard wheelchair. NA-A stated R7 used to wheel herself all over. During an observation on 1/13/16, at 8:34 a.m. staff pushed R7 down the hallway with footrests on the wheelchair.	F 309	An OT evaluation of the resident in questions was ordered and completed. A new wheelchair was ordered and has already arrived. The Care Plan was updated to reflect the changes resulting from the OT evaluation. The Director of Nursing and MDS nurse have reviewed the policies and procedures for care plan revisions. They reviewed care plans to make sure that they are accurate and up-to-date. The DON and MDS nurse have met individually with licensed staff, to review the need for the care plans to accurately reflect the care that is being provided. The MDS nurse will perform audits of Care Plans and will report her findings to the Quality Assurance Committee at its quarterly meeting.	

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	245440	A. BUILDING ______ B. WING ______	01/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	**102 EAST NORTH STREET JANESVILLE, MN 56048**

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F 309	Continued From page 6 During an observation on 1/13/15, at 11:42 a.m. R7 attempted to wheel self out of her room by using her hands on the wheels. R7 had a difficult time maneuvering the chair through her doorway. Licensed practical nurse (LPN)-A assisted R7 out of the room and then encouraged R7 to continue to self-propel chair and provided instructions on how to move the chair with her arms. R7 was able to move the chair with instruction and with difficulty; the chair moved mere inches a time. Total distance that R7 was able to move was approximately fifteen feet with assistance. R7's Cumulative Diagnosis List included; Parkinson's disease, dementia, cataracts, bipolar disorder, and major depressive disorder. R7's quarterly Minimum Data Set (MDS) dated 9/11/15, prior to the illness identified R7 had severe cognitive impairment with a Brief Interview for Mental Status Score (BIMS) of three. The assessment indicated R7 required extensive assist from one staff member for locomotion on and off the unit, had functional limitations in range of motion for both upper and lower extremities, and was unsteady with transfers. The MDS dated 12/11/15, showed a decline in R7's self-performance for locomotion; R7 was now dependent on one staff member for locomotion. The 12/11/15, assessment was compared to the 9/11/15 assessment; the 12/11 assessment reflected the same levels of activity performance for bed mobility, dressing, and transfers with an improvement in toileting from dependent to extensive assist. R7's electronic care plan provided by the facility on 1/14/15, did not reflect the dependent level of assistance for locomotion indicated on the	F 309		

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F 309	Continued From page 7	F 309		

12/11/15 assessment. The care plan indicated R7 did not ambulate, however, was independent with locomotion on and off the nursing units, but required staff to assist her to scheduled destinations. The care plan directed staff to encourage independence and maintain optimal level of functioning. The care plan further informed staff, "Enjoys wheeling around the facility on a daily basis."

R7's CNA Assignment Card was consistent with the care plan for locomotion on and off the unit.

R7's nursing progress notes were reviewed from 11/1/15 through 1/14/16 and noted:

-11/1/15 nursing progress noted included, "Resident has been tired this weekend. Napping in between meals and weak. She has a difficult time sitting upright in chair and pillows have been placed."

-11/8/15 nursing progress note included, "Resident leaning over in her wheelchair, repositioned resident in a reclining chair for comfort and to prevent injury. Resident has no c/o [complaints of] different chair, trys [sig] to wheel self as she did in old chair but will ask staff to take her to her room."

-11/17/15 nursing progress note assessment included, "Move off the unit: Requires one aide assist to move about off the unit. Is directed and or/enc. [encouraged] and occasionally given some physical assist to move about off unit. Devices: primary mode of locomotion is with wheelchair. Is wheeled by others. Infrequently his/her own wheelchair. Move on Unit: Requires one aide assist to move about the unit. Directed and/or encouraged with some occasional physical

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F 309	Continued From page 8	F 309		

assist to move about the unit."

-12/15/15 nursing progress note assessment included, "Move on unit: Requires one aide assist to move about the unit. Directed and/or encouraged with some occasional physical assist to move about the unit. Is able propel self short distances."

Physician visit note dated 11/3/15 indicated R7 had a urinary tract infection that resolved.

The record did not reflect an evaluation of the identified decline in locomotion or an updated plan of care related to the decline in locomotion. In addition, the care plan did not reflect revision related to R7's decline in locomotion or change in wheel chair.

During an interview on 1/13/15, director of nursing (DON) indicated awareness that R7's feet were dangling and had alerted maintenance for possible chair adjustments.

An interview on 1/13/15, at 11:44 a.m. with occupational therapist (OT)-A and certified occupational therapist assistant (COTA)-A was conducted. COTA-A indicated nursing had not requested a therapy evaluation for positioning. Stated R7 last completed therapy in August of 2014 for functional transfer training and upper body strengthening. OT-A explained residents should be referred for positioning when there is an increased need for assistant from what was previously provided, a change in positioning, with a change in condition, and when there is skin breakdown. OT-A indicated ideally nursing staff would communicate wheelchairs are changed out. OT-A stated from a therapy stand point, "we

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F 309	Continued From page 9	F 309		

would never recommend a Rock and Go wheel chair for any reason." COTA-A indicated screening was performed quarterly screens on everyone in the building to see if there is a need, however did not have a quarterly screen on file.

Facility policy Weekly Charting and Care Plan Review Policy last reviewed 9/13 included, "Week 3 ADL [activities of daily living} charting-Document in Nurses Notes-Review ADL Care Plan Problem.", and "update care plans when appropriate with scheduled weekly charting and daily as changes occur with residents."

The facility provided the policy Change in a Resident's Condition or Status last revised on 4/11. The policy directed staff to perform a comprehensive assessment if there was a significant change in the resident's physical or mental condition; however, did not include instruction for care plan revision nor implementation.

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

F 5440025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING 01 - MAIN BUILDING 01 B. WING ____	01/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on January 12, 2016. At the time of this survey, Janesville Nuring Home was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. Janesville Nursing Home is a 1-story with a partial basement facility was constructed in 1965, with one building addition constructed in 1994. Both buildings were determined to be of Type II(000) construction. The facility is fully fire sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 40 beds and had a census of 32 at time of the survey.	K 000		

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

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

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING **02 - 2008 LINK** B. WING ______	**01/12/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	**102 EAST NORTH STREET** **JANESVILLE, MN 56048**

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Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered
January 26, 2016

Mr. R. Peter Madel III, Administrator
Janesville Nursing Home
102 East North Street
Janesville, MN 56048

RE: Project Number S5440026

Dear Mr. Madel III:

On January 14, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

> **<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;**
>
> **<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**
>
> **<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.**

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
Email: Kathryn.serie@state.mn.us
Office: (507) 476-4233 Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 23, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 14, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 14, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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.

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00681	A. BUILDING: ______ B. WING ______	01/14/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00681	A. BUILDING: ______ B. WING ______	01/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	**102 EAST NORTH STREET JANESVILLE, MN 56048**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 1/11/2016, 1/12/2016, 1/13/2016 and 1/14/2016 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00681	A. BUILDING: ______ B. WING ______	01/14/2016

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to revise the care plan for 1 of 3 residents (R7) to reflect a change in mobility needs for locomotion reviewed for positioning. Findings included: During an observation on 1/11/2016, at 3:40 p.m. R7 was awake and sitting in Rock and Go wheel chair in her room. R7's feet were dangling approximately four inches from the floor. The chair did not have footrests for leg support on at this time. During an observation on 1/13/16, at 7:39 a.m. staff pushed R7 from dining room to her room in	2 570	Corrected	2/23/16

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2 570	Continued From page 3 Rock and Go wheel chair. R7's feet dangled approximately four inches from the floor, no footrests observed on the chair. During an interview at 8:17 a.m. nursing assistant (NA)-A indicated staff had not been using the foot pedals. NA-A explained R7 sometimes moved herself around. NA-A was asked how R7 moved around when her feet could not touch the floor, NA-A responded by explaining R7 had varying levels of energy. NA-A further explained nursing changed the chair to the Rock and Go because R7 had been sick and could not sit up in a standard wheelchair. NA-A stated R7 used to wheel herself all over. During an observation on 1/13/16, at 8:34 a.m. staff pushed R7 down the hallway with footrests on the wheelchair. During an observation on 1/13/16, at 11:42 a.m. R7 attempted to wheel self out of her room by using her hands on the wheels. R7 had a difficult time maneuvering the chair through her doorway. Licensed practical nurse (LPN)-A assisted R7 out of the room and then encouraged R7 to continue to self-propel chair and provided instructions on how to move the chair with her arms. R7 was able to move the chair with instruction and with difficulty; the chair moved mere inches at a time. Total distance that R7 was able to move was approximately fifteen feet with assistance. R7's quarterly Minimum Data Set (MDS) dated 9/11/15 prior to the illness identified R7 had severe cognitive impairment with a Brief Interview for Mental Status Score (BIMS) of three. The assessment indicated R7 required extensive assist from one staff member for locomotion on and off the unit, had functional limitations in range of motion for both upper and lower extremities, and was unsteady with transfers. The MDS dated 12/11/15 showed a decline in R7's self-performance for locomotion; R7 was now	2 570		

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2 570	Continued From page 4	2 570		

dependent on one staff member for locomotion. R7's electronic care plan provided by the facility on 1/14/15 did not reflect the dependent level of assistance for locomotion indicated on the 12/11/15 assessment. The care plan indicated R7 did not ambulate, however, was independent with locomotion on and off the nursing units, but required staff to assist her to scheduled destinations. The care plan directed staff to encourage independence and maintain optimal level of functioning. The care plan further informed staff, "Enjoys wheeling around the facility on a daily basis."
R7's CNA Assignment Card was consistent with the care plan for locomotion on and off the unit.
R7's nursing progress notes were reviewed from 11/1/15 through 1/14/16.
-11/8/15 nursing progress note included, "Resident leaning over in her wheelchair, repositioned resident in a reclining chair for comfort and to prevent injury. Resident has no c/o [complaints of] different chair, trys [sig] to wheel self as she did in old chair but will ask staff to take her to her room."
-11/17/15 nursing progress note assessment included, "Move off the unit: Requires one aide assist to move about off the unit. Is directed and or/enc. [encouraged] and occasionally given some physical assist to move about off unit. Devices: primary mode of locomotion is with wheelchair. Is wheeled by others. Infrequently his/her own wheelchair. Move on Unit: Requires one aide assist to move about the unit. Directed and/or encouraged with some occasional physical assist to move about the unit."
-12/15/15 nursing progress note assessment included, "Move on unit: Requires one aide assist to move about the unit. Directed and/or encouraged with some occasional physical assist to move about the unit. Is able propel self short

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2 570	Continued From page 5 distances." The care plan did not reflect revision related to R7's decline in locomotion or change in wheel chair. During an interview on 1/13/16, director of nursing (DON) indicated awareness the residents feet were dangling and had alerted maintenance for possible chair adjustments. An interview on 1/13/16, at 11:44 a.m. with occupational therapist (OT)-A and certified occupational therapist assistant (COTA)-A was conducted. COTA-A indicated nursing had not requested a therapy evaluation for positioning and stated R7 last completed therapy in August of 2014 for functional transfer training and upper body strengthening. OT-A explained residents should be referred for positioning when there is an increased need for assistant from what was previously provided, a change in positioning, with a change in condition, and when there is skin breakdown. OT-A indicated ideally nursing staff would communicate wheelchairs are changed out. OT-A stated from a therapy stand point, "we would never recommend a Rock and Go wheel chair for any reason." COTA-A indicated screening was performed quarterly screens on everyone in the building to see if there is a need, however did not have a quarterly screen on file. Facility policy Weekly Charting and Care Plan Review Policy last reviewed 9/13 included, "Week 3 ADL [activities of daily living} charting- Document in Nurses Notes-Review ADL Care Plan Problem.", and "update care plans when appropriate with scheduled weekly charting and daily as changes occur with residents." SUGGESTED METHOD OF CORRECTION: The facility could review their policies and procedures for care plan revisions. The facility could review resident care plans to ensure all services needed are care planned accordingly. The facility could	2 570		

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2 570	Continued From page 6 then develop and provide education to licensed staff on analyzing data collected from the comprehensive assessment in order to idenetify needed services. The facility could then develop and implement an auditing system as a part of their quality assurance program to maintain compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide proper positioning in a Rock and Go wheel chair and failed to evaluate the identified decline in mobility after an acute illness 1 of 3 (R7) reviewed for positioning. Findings include:	2 830	Corrected	2/23/16

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2 830	Continued From page 7 R7 had an acute illness in November 2015. During that time, the facility changed R7's standard wheel chair to a Rock and Go wheel chair (type of wheel chair that has a high back, large wheels, and rocks back and forth with movement.) The record reflects a decline in mobility during this time. The record lacked evidence the facility comprehensively assess the identified decline in mobility to restore previous level functioning or prevent further decline. During an observation on 1/11/2016, at 3:40 p.m. R7 was awake and sitting in Rock and Go wheel chair in her room. R7's feet were dangling approximately four inches from the floor. The chair did not have footrests for leg support on at this time. During an observation on 1/13/16, at 7:39 a.m. staff pushed R7 from dining room to her room in Rock and Go wheel chair. R7's feet dangled approximately four inches from the floor, no footrests observed on the chair. During an interview at 8:17 a.m. nursing assistant (NA)-A indicated staff had not been using the foot pedals. NA-A explained R7 sometimes moved herself around. NA-A was asked how R7 moved around when her feet could not touch the floor, NA-A responded by explaining R7 had varying levels of energy. NA-A further explained nursing changed the chair to the Rock and Go because R7 had been sick and could not sit up in a standard wheelchair. NA-A stated R7 used to wheel herself all over. During an observation on 1/13/16, at 8:34 a.m. staff pushed R7 down the hallway with footrests on the wheelchair.	2 830		

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2 830	Continued From page 8	2 830		

During an observation on 1/13/15, at 11:42 a.m. R7 attempted to wheel self out of her room by using her hands on the wheels. R7 had a difficult time maneuvering the chair through her doorway. Licensed practical nurse (LPN)-A assisted R7 out of the room and then encouraged R7 to continue to self-propel chair and provided instructions on how to move the chair with her arms. R7 was able to move the chair with instruction and with difficulty; the chair moved mere inches a time. Total distance that R7 was able to move was approximately fifteen feet with assistance.

R7's Cumulative Diagnosis List included; Parkinson's disease, dementia, cataracts, bipolar disorder, and major depressive disorder.

R7's quarterly Minimum Data Set (MDS) dated 9/11/15, prior to the illness identified R7 had severe cognitive impairment with a Brief Interview for Mental Status Score (BIMS) of three. The assessment indicated R7 required extensive assist from one staff member for locomotion on and off the unit, had functional limitations in range of motion for both upper and lower extremities, and was unsteady with transfers. The MDS dated 12/11/15, showed a decline in R7's self-performance for locomotion; R7 was now dependent on one staff member for locomotion. The 12/11/15, assessment was compared to the 9/11/15 assessment; the 12/11 assessment reflected the same levels of activity performance for bed mobility, dressing, and transfers with an improvement in toileting from dependent to extensive assist.

R7's electronic care plan provided by the facility on 1/14/15, did not reflect the dependent level of assistance for locomotion indicated on the 12/11/15 assessment. The care plan indicated

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2 830	Continued From page 9	2 830		

R7 did not ambulate, however, was independent with locomotion on and off the nursing units, but required staff to assist her to scheduled destinations. The care plan directed staff to encourage independence and maintain optimal level of functioning. The care plan further informed staff, "Enjoys wheeling around the facility on a daily basis."

R7's CNA Assignment Card was consistent with the care plan for locomotion on and off the unit.

R7's nursing progress notes were reviewed from 11/1/15 through 1/14/16 and noted:

-11/1/15 nursing progress noted included, "Resident has been tired this weekend. Napping in between meals and weak. She has a difficult time sitting upright in chair and pillows have been placed."

-11/8/15 nursing progress note included, "Resident leaning over in her wheelchair, repositioned resident in a reclining chair for comfort and to prevent injury. Resident has no c/o [complaints of] different chair, trys [sig] to wheel self as she did in old chair but will ask staff to take her to her room."

-11/17/15 nursing progress note assessment included, "Move off the unit: Requires one aide assist to move about off the unit. Is directed and or/enc. [encouraged] and occasionally given some physical assist to move about off unit. Devices: primary mode of locomotion is with wheelchair. Is wheeled by others. Infrequently his/her own wheelchair. Move on Unit: Requires one aide assist to move about the unit. Directed and/or encouraged with some occasional physical assist to move about the unit."

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2 830	Continued From page 10 -12/15/15 nursing progress note assessment included, "Move on unit: Requires one aide assist to move about the unit. Directed and/or encouraged with some occasional physical assist to move about the unit. Is able propel self short distances." Physician visit note dated 11/3/15 indicated R7 had a urinary tract infection that resolved. The record did not reflect an evaluation of the identified decline in locomotion or an updated plan of care related to the decline in locomotion. In addition, the care plan did not reflect revision related to R7's decline in locomotion or change in wheel chair. During an interview on 1/13/15, director of nursing (DON) indicated awareness that R7's feet were dangling and had alerted maintenance for possible chair adjustments. An interview on 1/13/15, at 11:44 a.m. with occupational therapist (OT)-A and certified occupational therapist assistant (COTA)-A was conducted. COTA-A indicated nursing had not requested a therapy evaluation for positioning. Stated R7 last completed therapy in August of 2014 for functional transfer training and upper body strengthening. OT-A explained residents should be referred for positioning when there is an increased need for assistant from what was previously provided, a change in positioning, with a change in condition, and when there is skin breakdown. OT-A indicated ideally nursing staff would communicate wheelchairs are changed out. OT-A stated from a therapy stand point, "we would never recommend a Rock and Go wheel chair for any reason." COTA-A indicated screening was performed quarterly screens on	2 830		

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2 830	Continued From page 11 everyone in the building to see if there is a need, however did not have a quarterly screen on file. Facility policy Weekly Charting and Care Plan Review Policy last reviewed 9/13 included, "Week 3 ADL [activities of daily living} charting-Document in Nurses Notes-Review ADL Care Plan Problem.", and "update care plans when appropriate with scheduled weekly charting and daily as changes occur with residents." The facility provided the policy Change in a Resident's Condition or Status last revised on 4/11. The policy directed staff to perform a comprehensive assessment if there was a significant change in the resident's physical or mental condition; however, did not include instruction for care plan revision nor implementation. SUGGESTED METHOD OF CORRECTION: The facility could review their policies and procedures for care plan revisions. The facility could review resident care plans to ensure all services needed are care planned accordingly. The facility could then develop and provide education to licensed staff on analyzing data collected from the comprehensive assessment in order to idenetify needed services. The facility could then develop and implement an auditing system as a part of their quality assurance program to maintain compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control	21426		2/16/16

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21426	Continued From page 12	21426		

(a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.

(b) Written compliance with this subdivision must be maintained by the nursing home.

This MN Requirement is not met as evidenced by:
Based on document review and interview the facility failed to ensure second step tuberculin skin tests (TSTs) were performed for 5 of 5 new employees reviewed according to the Center for Disease Control's (CDC) recommended guidelines for tuberculosis (TB) screening and prevention.
Findings included
Facility records indicated employee (EE)-1 was hired on 7/17/15. The record showed the first step TST was administered on 7/17/15. The record indicated the test was negative with 0 millimeters (ml) of induration, however the record did not indicate when the test was read. EE's record also showed the facility performed the TB

Provider's plan of correction: Corrected

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21426	Continued From page 13 symptom assessment screen on 7/21/15. The record lacked evidence administration of the second step TST. Facility employee records lacked evidence administration of the second step TST for EE-2, EE-3, EE-4, and EE-5. On 1/13/16 at approximately 2:00 p.m., the director of nursing indicated a change in infection control responsibility related to staff changes and confirmed the employee TB tests were not up to date. Facility policy Tuberculosis Exposure Plan last revised in March 2011 included, "A baseline mantoux [TST] will be obtained on all new employees. The baseline mantoux includes the two-step method for employees who have not had a documented negative tuberculin test during the previous 12 months." SUGGESTED METHOD OF CORRECTION: The facility could review their TB policies and procedures. The infection control coordinator or designee could review all employee medical files to ensure all employees are current and up to date with tuberculosis screening. The infection control coordinator or designee could then develop and implement an auditing system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21426		