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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: HPRV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00109

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245465**

2.STATE VENDOR OR MEDICAID NO.
(L2) **668340100**

3. NAME AND ADDRESS OF FACILITY
(L3) **COMMUNITY MEMORIAL HOME**
(L4) **410 WEST MAIN STREET**
(L5) **OSAKIS, MN** (L6) **56360**

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 **12/29/2016** (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)
06/30

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

12.Total Facility Beds **45** (L18)

13.Total Certified Beds **45** (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)
X 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A5*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(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):

Facility's request for a continuing waiver involving K521 is recommended.

17. SURVEYOR SIGNATURE — Date :
Kathy Lucas, Unit Supervisor — 12/29/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 01/26/2017 (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
04/01/1987
(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
Posted 02/01/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/13/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245465
January 26, 2017

Mr. David Carlson, Administrator
Community Memorial Home
410 West Main Street
Osakis, MN 56360

Dear Mr. Carlson:

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

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

Effective December 20, 2016 the above facility is certified for or recommended for:

45 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 skilled nursing facility beds.

Your request for waiver of K521 has been recommended based on the submitted documentation. You will receive notification from CMS only if they do not concur with our recommendation.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for this deficiency or renew your request for waiver in order to continue your participation in the Medicare Medicaid Program.

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 26, 2017

Mr. David Carlson, Administrator
Community Memorial Home
410 West Main Street
Osakis, MN 56360

RE: Project Number S5465027

Dear Mr. Carlson:

On November 29, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 10, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 29, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 4, 2017 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 November 10, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 20, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 10, 2016, effective December 20, 2016 and therefore remedies outlined in our letter to you dated November 29, 2016, will not be imposed.

Your request for a continuing waiver involving the deficiency(ies) cited under K521 at the time of the November 10, 2016 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245465 Y1	A. Building B. Wing Y2	12/29/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

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 F0157	Correction	ID Prefix F0280	Correction	ID Prefix F0323	Correction
Reg. # 483.10(b)(11)	Completed	Reg. # 483.20(d)(3), 483.10(k)(2)	Completed	Reg. # 483.25(h)	Completed
LSC	12/20/2016	LSC	12/20/2016	LSC	12/20/2016
ID Prefix F0329	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.25(l)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	12/20/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) KL/KJ	DATE 01/26/2017	SIGNATURE OF SURVEYOR 38202	DATE 12/29/2016
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?
11/10/2016	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245465 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	1/4/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0291	12/20/2016	LSC K0321	12/20/2016	LSC K0363	12/20/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0521	12/20/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 01/26/2017	SIGNATURE OF SURVEYOR 36536	DATE 01/04/2017
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?
11/10/2016	☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: HPRV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00109

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245465**

2.STATE VENDOR OR MEDICAID NO.
(L2) **668340100**

3. NAME AND ADDRESS OF FACILITY
(L3) **COMMUNITY MEMORIAL HOME**
(L4) **410 WEST MAIN STREET**
(L5) **OSAKIS, MN** (L6) **56360**

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 **11/10/2016** (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)
06/30

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

12.Total Facility Beds **45** (L18)

13.Total Certified Beds **45** (L17)

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

X 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: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(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 :
Annette Truebenbach, HFE NE II 12/08/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 01/13/2017 (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
04/01/1987
(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
Emailed ROCHI AW K521 01/13/2017 Co.
Posted 01/13/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
November 29, 2016

Mr. David Carlson, Administrator
Community Memorial Home
410 West Main Street
Osakis, MN 56360

RE: Project Number S5465027

Dear Mr. Carlson:

On November 10, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - the type of remedies that will be imposed with the authorization of the

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

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:

Kathy Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing & Certification
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7343
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 20, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 20, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by February 10, 2017 (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 May 10, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

(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 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC 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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in	F 157		12/20/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/07/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 1 resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to promptly notify the physician regarding abnormal vital signs for 1 of 1 residents (R21) who experienced hypotension (low blood pressures). Findings Include: R21's admission Minimum Data Set, dated 7/1/16, indicated a moderate cognitive impairment and a diagnosis of hypertension (high blood pressure). Hospital admission, progress, and discharge records, dated 6/23/16 to 6/28/16, indicated R21 was treated for sepsis (blood infection) and identified additional diagnosis including superventricular tachycardia (rapid heartbeat) and heart murmur. Further review of the hospital records indicated the following blood pressures (BP) for R2: (normal BP range is between 140/90 and 90/50) - On 6/23/16, BP was 116/61 millimeters of mercury (mmHg). - On 6/24/16, BP was 117/50 mmHg. - On 6/25/16, BP was 126/36 mmHg. - On 6/26/16, BP was 134/45 mmHg.	F 157	F157 R21 was identified to be effected by the deficient practice. Facility failed to promptly notify the physician regarding abnormal vital signs who experienced hypotension. R21 passed away on 7/2/16. Residents in the facility with a diagnosis of hypertension or hypotension will be identified. Guidelines will be established for blood pressure monitoring for both high and low pressures. All vital signs will be reviewed and entered into the electronic health record by licensed staff. Any abnormal vital signs noted will be checked by licensed nursing staff within 30 minutes. The physician will be notified via telephone if blood pressures are high or low as soon as possible if the resident is symptomatic. If the resident has abnormal blood pressures and is asymptomatic a fax will be sent to the physician for his review. The facility will monitor its performance with audits by the DON and RN Supervisory Staff daily for 2 weeks then bi weekly for 2 weeks and then weekly for four weeks. All Nursing Staff will be educated at the Nurses Meeting on December 7th. This will also reviewed at the Quality Assurance	

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F 157	Continued From page 2 - On 6/27/16, BP was 140/41 mmHg. - On 6/28/16, BP was 100/31 mmHg. Review of facility document entitled Weights and Vitals Summary identified R21's BP reading as follows: - On 6/28/16, at 1:00 p.m. BP was 108/59 mmHg. - On 6/29/16, at 9:30 a.m. BP was 84/51 mmHg. - On 6/30/16, at 8:41 p.m. BP was 85/54 mmHg. - On 7/1/16, at 1:29 p.m. BP was 81/43 mmHg. - On 7/1/16, at 8:02 p.m. BP was 84/47 mmHg. There was no indication in R21's medical record that the primary physician had been notified of the hypotension. During interview on 11/10/16, beginning at 9:18 a.m. registered nurse (RN)-A stated R21's BP's were "A little low," but thought they were low with similar values during R21's hospital admission. However, R21's BP had dropped over 20 mmHg below her previous readings. RN-A stated R21 was always lying in bed during the BP readings contributing to the hypotension. RN-A further stated the physician would be notified of values outside the normal for the resident. During interview on 11/10/16, at 12:02 p.m. physician (MD)-A stated he had not visited R21 since her admission to the facility, he had received a fax notification on 6/30/16 regarding R21's mood state, but that he was not notified of R21's blood pressures. MD-A further stated if the BP dropped more than 20 mmHg, he would have altered R21's plan of care by holding BP medications or provided parameters.	F 157	Meeting on December 20, 2016. Corrective Action will be completed by December 20, 2016.	

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F 157	Continued From page 3 Nursing progress notes dated 7-2-16, indicated R21 passed away in the morning of 7-2-16. A facility policy entitled Physician Notification- RN on Call, dated 12/17/07, directed staff to notify the physician of significant changes or when there is a need to significantly alter treatment.	F 157		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan to include new fall interventions assessed to be implemented following a fall for 1 of 3 residents	F 280	F280 R53 was identified as being effected by the deficient practice. Facility failed to revise the care plan to include the new fall intervention assessed to be	12/20/16

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F 280	Continued From page 4 (R53) reviewed for falls. Findings include: R53's annual Minimum Data Set (MDS) dated 10/13/16, indicated R53 had severe cognitive impairment and needed extensive assistance with transfers. R53's MDS included a diagnosis of Alzheimer's disease. R53's Post Fall Review dated 10/21/16, indicated R53 had a fall from bed on 10/19/16. The review indicated that the monitoring alarm did not activate when R53 attempted to get out of bed as the alarm was placed to the outside of the bed. The review indicated the care plan was revised to include that the monitoring device was placed on the bed closer to the wall, so that the alarm would activate, notifying staff that R53 was up and moving. R53's care plan dated 10/29/16, directed staff that R53 utilized a TABS alarm (monitoring alarm) in bed to alert staff to R53's self transfer attempts. The care plan did not indicate where the alarm should be placed on R53's bed. During observation on 11/10/16, at 9:09 a.m. R53 was sleeping on the right side facing the wall, the bed was in a low position and a fall matt was on the floor to the outside of the bed. A monitoring alarm was observed to be attached to the bed near the outside of the bed, rather than closer to the wall as specified in the Post Fall Review, with the string attached to R53's shirt. During interview on 11/10/16, at 9:16 a.m. nursing assistant (NA)-A stated that she was not aware that the monitoring alarm was to be placed on the	F 280	implemented following a fall for R53. R53□s care plan and Kardex was updated on 11/12/16 to show proper placement of the alarm on the residents□ bed near the wall. All residents with identified fall histories will have their care plans and kardex□s reviewed to make sure all fall interventions are on the care plan and kardex. Each resident and resident room of those identified will also be assessed to make sure all interventions are in place. All future falls will be reviewed at daily nursing stand-up meetings, Monday thru Friday. Fall Interventions will be entered into the Electronic Health Record Care Plan immediately following the implementation of the new intervention. The Kardex will also be printed at this time and placed into the resident□s room. Verbal reports of updated care plans will be given to all nursing staff on duty and upon shift change. The DON or Designee will audit fall incidents weekly for 12 weeks to ensure that the Resident Care Plan and Kardex are updated with new fall interventions and that new fall interventions are implemented with the resident or resident room. All Nursing Staff will be educated at the Nurses Meeting on December 7th. This will also reviewed at the Quality Assurance Meeting on December 20th 2016. Corrective Action will be completed by December 20, 2016.	

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F 280	Continued From page 5 bed near the wall. NA-A stated that fall interventions are verbalized in report and then the care plan is updated and the nurse would print out a new Kardex (tool to direct care) for the nursing assistants to follow. NA-A observed the Kardex in R53's room dated 10/29/16, and stated the Kardex did not direct the staff to where to place the monitoring alarm. During interview on 11/10/16, at 9:24 a.m. trained medication assistant (TMA)-A stated that it would be important for the care plan to reflect where to place the monitoring alarm. During interview on 11/10/16, at 9:40 a.m. registered nurse (RN)-A stated that the care plan was not updated following R53's fall indicating where the monitoring alarm should be placed. During interview on 11/10/16, at 10:02 a.m. the director of nursing stated that the care plan should have been updated to reflect the location of where the monitoring alarm should be placed, as it was important to attempt to prevent further falls from bed. The undated facility policy Care Plans, Nursing indicated the nursing supervisor was responsible to ensure that the care plan was accurate and timely.	F 280		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		12/20/16

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F 323	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement assessed fall interventions for 1 of 3 residents (R53) reviewed for falls. Findings include: R53's annual Minimum Data Set (MDS) dated 10/13/16, indicated R53 had severe cognitive impairment and needed extensive assistance with transfers. R53's MDS included a diagnosis of Alzheimer's disease. R53's falls Care Area Assessment (CAA) dated 10/27/16, indicated R53 was at risk to fall due to altered cognition, wandering, intermittent restlessness, incontinence and the use of psychotropic (mood altering) medications. The CAA indicated a goal for R53 to avoid complications and minimize the risk of falling. R53's Post Fall Review dated 10/21/16, indicated R53 had a fall from bed on 10/19/16, the review indicated that the monitoring alarm did not activate when R53 attempted to get out of bed as the alarm was placed to the outside of the bed. The review indicated the care plan was revised to include that the monitoring device was placed on the bed closer to the wall, so that the alarm would activate, notifying staff that R53 was up and moving. R53's care plan dated 10/29/16, directed staff	F 323	F323 R53 was affected by the deficient practice. Facility failed to implement fall interventions following assessment. Facility did not follow accident/incident policy. All residents with identified fall histories will have their care plans and kardex□s reviewed to make sure all fall interventions are on the care plan and kardex. Each resident and resident room of those identified will also be assessed to make sure all interventions are in place. All future falls will be reviewed at daily nursing stand-up meetings Monday thru Friday. Upon updated Kardex being placed in the resident room the licensed staff will implement the new intervention immediately. Verbal reports of the updated care plan kardex will be given to all nursing staff during shift change reports. The DON or Designee will audit fall incident interventions weekly for 12 weeks to ensure that the Resident Care Plan and Kardex are updated with new fall interventions and that new fall interventions are implemented with the resident or resident room. All Nursing Staff will be educated at the Nurses Meeting on December 7th. This will also reviewed at the Quality Assurance Meeting on December 20th 2016. Corrective Action will be completed by December 20, 2016.	

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F 323	Continued From page 7	F 323		

that R53 utilized a tabs alarm (monitoring alarm) in bed to alert staff to R53's self transfer attempts. The care plan did not indicate where the alarm should be placed on R53's bed.

During observation on 11/10/16, at 9:09 a.m. R53 was sleeping on her right side facing the wall, the bed was in a low position and a fall matt was on the floor to the outside of the bed. A monitoring alarm was observed to be attached to the bed near the outside of the bed, rather than closer to the wall as indicated on the Post Fall Review, with the string attached to R53's shirt.

During interview on 11/10/16, at 9:16 a.m. nursing assistant (NA)-A stated that R53's alarm was on the outside of the bed. NA-A stated that she was not aware that the monitoring alarm was to be placed on the bed near the wall. NA-A stated that fall interventions are verbalized in report and then the care plan is updated and the nurse would print out a new Kardex (tool to direct care) for the aids to follow. NA-A observed the Kardex in R53's room dated 10/29/16, and stated the Kardex did not direct the staff where to place the monitoring alarm.

During interview on 11/10/16, at 9:24 a.m. trained medication assistant (TMA)-A stated that R53's monitoring alarm was supposed to be placed on the bed near the wall, otherwise if R53 attempted to get out of bed the alarm would not sound. After review of the Kardex dated 10/29/16, TMA-A stated that it would be important for the care plan to reflect where to place the monitoring alarm.

During interview on 11/10/16, at 9:40 a.m. registered nurse (RN)-A that following the post fall review any new interventions assessed to be

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F 323	Continued From page 8 appropriate are then added to the care plan. RN-A further stated that a Kardex that is linked to the care plan is then printed for the nursing assistants to follow. RN-A stated that prior to the fall on 10/18/16, R53 did have a monitoring alarm and that during the fall it did not sound. RN-A stated the intervention was to place the monitoring alarm on the bed near the wall. RN-A further stated that the care plan was not updated to reflect the placement of the monitoring alarm. During interview on 11/10/16, at 10:02 a.m. the director of nursing (DON) stated the monitoring alarm should have been placed near the wall and that the care plan should have been updated to reflect the location the monitoring alarm should be placed, as it was important to attempt to prevent further falls from bed. The facility Resident Incident/Accident policy revised 12/14, directed staff to complete a post fall assessment and identify a root cause, if possible, and prevent future recurrences of a similar type of incident. The policy also directed staff to determine changes to the plan of care as indicated.	F 323		
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	F 329		12/20/16

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F 329	Continued From page 9 combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to adequately monitor cardiovascular medications for 1 of 6 residents (R21) who received blood pressure medications and diuretics (pills to treat high blood pressure) while experiencing hypotension (low blood pressures). Findings Include: R21's admission Minimum Data Set, dated 7/1/16, indicated a moderate cognitive impairment and a diagnosis of hypertension (high blood pressure). Hospital admission, progress, and discharge records, dated 6/23/16 to 6/28/16, indicated R21 was treated for sepsis (blood infection) and identified additional diagnosis including superventricular tachycardia (rapid heartbeat)	F 329	F329 R21 was affected by the deficient practice. Facility failed to adequately monitor cardiovascular medications for a resident who received blood pressure medications and diuretic pills to treat high blood pressure when experiencing hypotension or low blood pressure. There was no indication that the physician had been notified of the hypotension. R21 passed away on 7/2/16. Residents in the facility with a diagnosis of hypertension or hypotension will be identified. Upon admission all residents will have their vital signs taken each shift daily for three days to establish a baseline. After that, vital signs will be completed weekly or more often per physician order. All vital signs will be reviewed and entered into the electronic health record by licensed staff.	

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F 329	Continued From page 10 and heart murmur. Further review of the hospital records indicated the following blood pressures (BP) for R21: (normal BP range is between 140/90 and 90/50) - On 6/23/16, BP was 116/61 millimeters of mercury (mmHg). - On 6/24/16, BP was 117/50 mmHg. - On 6/25/16, BP was 126/36 mmHg. - On 6/26/16, BP was 134/45 mmHg. - On 6/27/16, BP was 140/41 mmHg. - On 6/28/16, BP was 100/31 mmHg. R21's current physician orders, dated 6/28/16, indicated R21 received the following medications: - Lopressor (BP medication) 100 milligrams (mg) everyday in the morning. - Lopressor 200 mg everyday before bed. - Lasix (diuretic medication) 20 mg everyday in the morning. Review of facility document entitled Weights and Vitals Summary identified R21's BP readings as follows: - On 6/28/16, at 1:00 p.m. BP was 108/59 mmHg. - On 6/29/16, at 9:30 a.m. BP was 84/51 mmHg. - On 6/30/16, at 8:41 p.m. BP was 85/54 mmHg. - On 7/1/16, at 1:29 p.m. BP was 81/43 mmHg. - On 7/1/16, at 8:02 p.m. BP was 84/47 mmHg. R21's Medication Administration Record (MAR), dated 6/28/16 to 7/1/16, indicated R21 received scheduled doses of Lopressor and Lasix concurrently with the BP's above. There was no indication in R21's medical record that the primary physician had been notified of the	F 329	Any abnormal vital signs noted will be checked by licensed nursing staff within 30 minutes. The health care provider will be notified via telephone if blood pressures are high or low with information about all medications the resident is receiving as soon as possible if the resident is symptomatic. If the resident has abnormal blood pressures and is asymptomatic a fax with an update and a list of cardiovascular medications will be sent to the physician for his review. The facility will monitor its performance with audits by the DON and RN Supervisory Staff daily for 2 weeks then bi weekly for 2 weeks and then weekly for four weeks. All Nursing Staff will be educated at the Nurses Meeting on December 7th. This will also reviewed at the Quality Assurance Meeting on December 20th 2016. Corrective Action will be completed by December 20, 2016.	

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F 329	Continued From page 11	F 329		

hypotension.

During interview on 11/10/16, beginning at 9:18 registered nurse (RN)-A stated R21's BP's were "A little low," but thought they were low with similar values during R21's hospital admission. However, R21's BP had dropped over 20 mmHg below her previous readings. RN-A stated R21 was always lying in bed during the BP readings contributing to the hypotension. RN-A reported R21 received her scheduled BP medications everyday as staff did not have parameters to hold them. RN-A stated the physician would be notified of values outside the normal for the resident, further stating physicians were "Reluctant to give parameters."

During interview on 11/10/16, at 11:10 a.m. the Director of Nursing (DON) stated the interdisciplinary team concluded R21's lower BP's were similar to her hospitalization BP's, indicating R21's BP's were stable. The DON stated R21 wasn't eating well and thought that RN-A had updated the physician.

During interview on 11/10/16, at 12:02 p.m. physician (MD)-A stated he had not visited R21 since her admission to the facility, he had received a fax notification on 6/30/16 regarding R21's mood state, but stated he was not notified of R21's blood pressures. MD-A further stated if the BP dropped more than 20 mmHg, he would have altered R21's plan of care by holding BP medications or provided parameters, especially if R21's intakes were poor.

Review of R21's food and fluid intakes, from 6/28/16 to 7/1/16, identified R21 had poor intakes consisting of 25% (percent) to no consumption of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

(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 meals and often refused snacks. Nursing progress notes dated 7-2-16, indicated R21 passed away in the morning of 7-2-16. A facility policy entitled Physician Notification- RN on Call, dated 12/17/07, directed staff to notify the physician of significant changes or when there is a need to significantly alter treatment.	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/10/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET** **OSAKIS, MN 56360**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, the 1963 and 1977 sections of Community Memorial Home were found to be 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 2012 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 STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/07/2016

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.

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	245465	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/10/2016**

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility was surveyed as one building. Community Memorial Home is a 2 story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1963, is one story and was determined to be of Type II(000) construction. In 1977, a one story, Type II(000), expansion to the dining room was added. In 2008 a 2 story Wellness Center was added. As of Nov 1, 2016 all sections are considered existing and were surveyed as one building. The building is fully fire sprinkler throughout. The facility has a fire alarm system that includes smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The resident rooms have battery operated smoke detectors. The facility has a capacity of 45 beds and had a census of 32 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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	245465	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/10/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 291 SS=E	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is not met as evidenced by: Based on observations and staff interview the facility failed to maintain emergency lighting in accordance with the provisions of the 2012 Life Safety Code, (NFPA 101) section 7.9.2. The deficient practice could negatively affect the ability to exit in the case of a power failure. This could affect and undetermined amount of residents, staff and visitors. Findings include, On the facility tour between 08:00 am and 12:00 pm on 11/10/2016 observations and staff interview revealed the emergency lights in the Wellness Center failed to operate when tested. This deficient condition was confirmed by the Director of Environmental Services .	K 291	K291 By 12-20-16 or sooner, the Director of Environmental Services will restore automatic emergency ligh The Director will then, by 12-20-16, inspect all other emergency lights within the wellness center to ensure their operability. To ensure future compliance, the Director of Environmental Services will monitor and verify through his/her signature that all emergency lights within the wellness center are tested and operable on a monthly basis.	12/20/16
K 321 SS=E	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.	K 321		12/20/16

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET** **OSAKIS, MN 56360**

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K 321	Continued From page 3 Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Seperation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K3220) This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to construct 2 soiled utility rooms in accordance with the 2012 Life Safety Code, (NFPA 101) section 19.3.2.1.3. This deficient practice could allow for smoke or fire to enter the corridor making it untenable for exiting, affecting 24 of the 32 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 08:00 am and 12:00 pm on 11/10/2016 observations and staff interview revealed shower rooms 10 and 30 were converted to soiled utility rooms and were not equipped with automatic door closer's. This deficient condition was confirmed by the Director of Environmental Services .	K 321	K321 By 12-20-16 or sooner, the Director of Environmental Services will install an automatic door closing device on each of the identified doors to shower rooms #10 and #30. To ensure future compliance, the Director of Environmental Services will document w/signature that these closers along with all others in the building are operable, functioning as expected, and achieving a positive latch.	
K 363 SS=E	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING	K 363		12/20/16

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K 363	Continued From page 4 Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to provide one corridor door with a means suitable for keeping the door closed in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.6.3.5. This deficient practice could allow for smoke to enter the corridor making it difficult to exit in the case of	K 363	K363 By 12-20-16 or sooner, the Director of Environmental Services will repair the #12 linen closet door located in the east corridor so that it achieves a positive latch upon being closed. The Director of Environmental Services will then monitor that door and all others in the building on	

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K 363	Continued From page 5 fire, affecting 12 of the 32 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 08:00 am and 12:00 pm on 11/10/2016 observations and staff interview revealed the linen closet, #12 in the east corridor did not positively latch. This deficient condition was confirmed by the Director of Environmental Services .	K 363	a monthly basis to ensure that they are operable and achieving a positive latch.	
K 521 SS=F	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility is using the corridors as part of the air distribution system to provide make-up air for the sleeping rooms' bathroom exhaust, throughout the building which is not in accordance with NFPA 90A. This deficient practice could allow the products of combustion to travel far from the fire origin and negatively affect all residents, staff and visitors by restricting their means of egress in a fire situation.. Findings include: On the facility tour between 08:00 am and 12:00	K 521	K521 A waiver continuation for K521 has been requested for which justification dated 12-5-16 on form CMS 2786R was attached.	12/20/16

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K 521	Continued From page 6 pm on 11/10/2016 observations and staff interview revealed that the HVAC systems for all wings in the 1963 and 1977 additions have ducted air supply to the corridors and hot water baseboard heat in the resident rooms. There are no return air ducts in the resident rooms and the corridor is being used as a return plenum. This deficient condition was confirmed by the Director of Environmental Services .	K 521		

Name of Facility

Community Memorial Home at Osakis, MN Inc. dba Galeon

2000 CODE 2012

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K521 Heating, Ventilation and Air Conditioning (HVAC) equipment at CMH does not comply with LSC Chapter 19 and NFPA 90A, 2012 Edition because the corridors are used as a plenum.	A continuing waiver is being requested for K521 for the following reasons: A. An extreme financial hardship on Community Memorial Home (CMH) will result from compliance because: 1. 11-5-16 estimates for compliance (attached) with NFPA 90A show that it will cost between $482,523.00 and $638,677.00. Funding for this expense is not available under current reimbursement rules; 2. The electrical system at CMH would need to be modified at a cost that may exceed $40,161.00; 3. Asbestos abatement required during installation would cost between $64,336.00 and $90,295.00; and 4. Non-complying systems are allowed to be used under LSC 9.2. B. If this waiver is approved, the safety of building occupants will not be compromised because: 1. CMH was built under Type II construction standards; 2. Walls, floors, ceilings and vertical openings at CMH already resist the passage of smoke; 3. CMH is completely protected by a supervised sprinkler system installed in accordance with NFPA 13; 4. HVAC ventilation fans automatically shut down upon fire alarm activation or the detection of smoke; 5. Resident sleeping rooms are all equipped with single station battery operated smoke detectors; 6. The property of CMH is smoke and tobacco free with signs posted to that effect; 7. All CMH corridors are equipped with a compliant UL listed smoke detection system; 8. The local fire department is located 6 blocks away and will respond to an alarm in less than 10 mins; 9. CMH has an approved fire safety plan and is compliant with all other fire safety requirements; and 10. A continuing waiver has been approved annually in the past for Community Memorial Home. Requested by: David E Carlson 12-5-16 David E. Carlson, Administrator 12-5-2016

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)* Thomas Linhoff 12424	Title Fire Safety Supervisor	Office State Fire Marshal	Date 12-09-2016

ra morton
CONSTRUCTION MANAGERS

3315 Roosevelt Road • Suite 100
St. Cloud, MN 56301

Bus 320.251.0262
Fax 320.251.5749

www.ramorton.com

December 5, 2016

Dave Carlson, Administrator
Galeon
410 West Main Street
Osakis, MN 56360

Dear Dave,

Per our conversation on Friday, December 2, 2016, costs for complying with NFPA 90A are shown in the Preliminary Master Budget that is attached. Please consider the high and low ranges provided in the budget to be our current estimate of cost.

Thank you.

Sincerely,

Preston Euerle
President/CEO

PRELIMINARY MASTER BUDGET
Galeon - Community Memorial Home
PREPARED: 12/5/2016

morton
CONSTRUCTION MANAGERS
"right from the start"
3315 Roosevelt Road, Ste. 100
St. Cloud MN 56301
Bus. (320) 251-0262 Fax: (320) 251-5749

	Low Range 24,000 S.F. DOLLARS		High Range 24,000 S.F. DOLLARS	
I. LAND				
SUBTOTAL LAND	$ -		$ -	
II. CONSTRUCTION COSTS				
GENERAL CONDITIONS	$ 28,687	$ 1.20	$ 35,774	$ 1.49
INTERIOR FINISHES / DEMO	$ 20,654	$ 0.86	$ 32,197	$ 1.34
MECHANICAL	$ 220,314	$ 9.18	$ 286,191	$ 11.92
FIRE SPRINKLER	$ 5,737	$ 0.24	$ 11,925	$ 0.50
ELECTRICAL	$ 40,161	$ 1.67	$ 47,699	$ 1.99
CONTINGENCY	$ 32,448	$ 1.35	$ 41,895	$ 1.75
SUBTOTAL CONSTRUCTION COSTS	$ 348,002	$ 14.50	$ 455,680	$ 18.99
III. SOFT COSTS				
FEES / PERMITS / PRINTING	$ 70,185	$ 2.92	$ 92,703	$ 3.86
OTHER	$ -	$ -	$ -	$ -
SUBTOTAL SOFT COSTS	$ 70,185	$ 2.92	$ 92,703	$ 3.86
IV. OWNER ITEMS				
FURNITURE/FIXTURES/EQUIPMENT	$ -		$ -	
OTHER - ASBESTOS ABATEMENT	$ 64,336	$ 2.68	$ 90,295	$ 3.76
SUBTOTAL OWNER ITEMS COSTS	$ 64,336	$ 2.68	$ 90,295	$ 3.76
V. TOTAL PROJECT COST	$ 482,523	$ 20.11	$ 638,677	$ 26.61

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted
November 29, 2016

Mr. David Carlson, Administrator
Community Memorial Home
410 West Main Street
Osakis, MN 56360

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5465027

Dear Mr. Carlson:

The above facility was surveyed on November 7, 2016 through November 10, 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 immediately contact Kathy Lucas, Unit Supervisor at (320) 223-7343.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

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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		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(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 November 7th -10th, 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. THIS WILL APPEAR ON EACH PAGE.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: _____ B. WING _____	11/10/2016

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or	2 265		12/20/16

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2 265	Continued From page 3 E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to promptly notify the physician regarding abnormal vital signs for 1 of 1 residents (R21) who experienced hypotension (low blood pressures). Findings Include: R21's admission Minimum Data Set, dated 7/1/16, indicated a moderate cognitive impairment and a diagnosis of hypertension (high blood pressure). Hospital admission, progress, and discharge records, dated 6/23/16 to 6/28/16, indicated R21 was treated for sepsis (blood infection) and identified additional diagnosis including superventricular tachycardia (rapid heartbeat) and heart murmur. Further review of the hospital records indicated the following blood pressures (BP) for R2: (normal BP range is between 140/90 and 90/50) - On 6/23/16, BP was 116/61 millimeters of mercury (mmHg). - On 6/24/16, BP was 117/50 mmHg. - On 6/25/16, BP was 126/36 mmHg. - On 6/26/16, BP was 134/45 mmHg. - On 6/27/16, BP was 140/41 mmHg. - On 6/28/16, BP was 100/31 mmHg. Review of facility document entitled Weights and Vitals Summary identified R21's BP reading as follows:	2 265	Corrected	

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2 265	Continued From page 4 - On 6/28/16, at 1:00 p.m. BP was 108/59 mmHg. - On 6/29/16, at 9:30 a.m. BP was 84/51 mmHg. - On 6/30/16, at 8:41 p.m. BP was 85/54 mmHg. - On 7/1/16, at 1:29 p.m. BP was 81/43 mmHg. - On 7/1/16, at 8:02 p.m. BP was 84/47 mmHg. There was no indication in R21's medical record that the primary physician had been notified of the hypotension. During interview on 11/10/16, beginning at 9:18 a.m. registered nurse (RN)-A stated R21's BP's were "A little low," but thought they were low with similar values during R21's hospital admission. However, R21's BP had dropped over 20 mmHg below her previous readings. RN-A stated R21 was always lying in bed during the BP readings contributing to the hypotension. RN-A further stated the physician would be notified of values outside the normal for the resident. During interview on 11/10/16, at 12:02 p.m. physician (MD)-A stated he had not visited R21 since her admission to the facility, he had received a fax notification on 6/30/16 regarding R21's mood state, but that he was not notified of R21's blood pressures. MD-A further stated if the BP dropped more than 20 mmHg, he would have altered R21's plan of care by holding BP medications or provided parameters. Nursing progress notes dated 7-2-16, indicated R21 passed away in the morning of 7-2-16. A facility policy entitled Physician Notification- RN on Call, dated 12/17/07, directed staff to notify the physician of significant changes or when there is a need to significantly alter treatment.	2 265		

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2 265	Continued From page 5 SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures, conduct audits related to Notification of Change in residents health to ensure practioners are notified of changes in residents condition accurately. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed 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. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan to include new fall interventions assessed to be implemented following a fall for 1 of 3 residents (R53) reviewed for falls.	2 555	Corrected	12/20/16

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2 555	Continued From page 6 Findings include: R53's annual Minimum Data Set (MDS) dated 10/13/16, indicated R53 had severe cognitive impairment and needed extensive assistance with transfers. R53's MDS included a diagnosis of Alzheimer's disease. R53's Post Fall Review dated 10/21/16, indicated R53 had a fall from bed on 10/19/16. The review indicated that the monitoring alarm did not activate when R53 attempted to get out of bed as the alarm was placed to the outside of the bed. The review indicated the care plan was revised to include that the monitoring device was placed on the bed closer to the wall, so that the alarm would activate, notifying staff that R53 was up and moving. R53's care plan dated 10/29/16, directed staff that R53 utilized a TABS alarm (monitoring alarm) in bed to alert staff to R53's self transfer attempts. The care plan did not indicate where the alarm should be placed on R53's bed. During observation on 11/10/16, at 9:09 a.m. R53 was sleeping on the right side facing the wall, the bed was in a low position and a fall matt was on the floor to the outside of the bed. A monitoring alarm was observed to be attached to the bed near the outside of the bed, rather than closer to the wall as specified in the Post Fall Review, with the string attached to R53's shirt. During interview on 11/10/16, at 9:16 a.m. nursing assistant (NA)-A stated that she was not aware that the monitoring alarm was to be placed on the bed near the wall. NA-A stated that fall interventions are verbalized in report and then the	2 555		

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2 555	Continued From page 7	2 555		

care plan is updated and the nurse would print out a new Kardex (tool to direct care) for the nursing assistants to follow. NA-A observed the Kardex in R53's room dated 10/29/16, and stated the Kardex did not direct the staff to where to place the monitoring alarm.

During interview on 11/10/16, at 9:24 a.m. trained medication assistant (TMA)-A stated that it would be important for the care plan to reflect where to place the monitoring alarm.

During interview on 11/10/16, at 9:40 a.m. registered nurse (RN)-A stated that the care plan was not updated following R53's fall indicating where the monitoring alarm should be placed.

During interview on 11/10/16, at 10:02 a.m. the director of nursing stated that the care plan should have been updated to reflect the location of where the monitoring alarm should be placed, as it was important to attempt to prevent further falls from bed.

The undated facility policy Care Plans, Nursing indicated the nursing supervisor was responsible to ensure that the care plan was accurate and timely.

SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is revised and followed. The DON or designee could develop a system to educate staff and a monitoring system to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty-one

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2 555	Continued From page 8 (21) days.	2 555		
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 implement assessed fall interventions for 1 of 3 residents (R53) reviewed for falls. Findings include: R53's annual Minimum Data Set (MDS) dated 10/13/16, indicated R53 had severe cognitive impairment and needed extensive assistance with transfers. R53's MDS included a diagnosis of Alzheimer's disease. R53's falls Care Area Assessment (CAA) dated 10/27/16, indicated R53 was at risk to fall due to altered cognition, wandering, intermittent restlessness, incontinence and the use of	2 830	Corrected.	12/20/16

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2 830	Continued From page 9	2 830		

psychotropic (mood altering) medications. The CAA indicated a goal for R53 to avoid complications and minimize the risk of falling.

R53's Post Fall Review dated 10/21/16, indicated R53 had a fall from bed on 10/19/16, the review indicated that the monitoring alarm did not activate when R53 attempted to get out of bed as the alarm was placed to the outside of the bed. The review indicated the care plan was revised to include that the monitoring device was placed on the bed closer to the wall, so that the alarm would activate, notifying staff that R53 was up and moving.

R53's care plan dated 10/29/16, directed staff that R53 utilized a tabs alarm (monitoring alarm) in bed to alert staff to R53's self transfer attempts. The care plan did not indicate where the alarm should be placed on R53's bed.

During observation on 11/10/16, at 9:09 a.m. R53 was sleeping on her right side facing the wall, the bed was in a low position and a fall matt was on the floor to the outside of the bed. A monitoring alarm was observed to be attached to the bed near the outside of the bed, rather than closer to the wall as indicated on the Post Fall Review, with the string attached to R53's shirt.

During interview on 11/10/16, at 9:16 a.m. nursing assistant (NA)-A stated that R53's alarm was on the outside of the bed. NA-A stated that she was not aware that the monitoring alarm was to be placed on the bed near the wall. NA-A stated that fall interventions are verbalized in report and then the care plan is updated and the nurse would print out a new Kardex (tool to direct care) for the aids to follow. NA-A observed the Kardex in R53's room dated 10/29/16, and stated the Kardex did

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2 830	Continued From page 10 not direct the staff where to place the monitoring alarm. During interview on 11/10/16, at 9:24 a.m. trained medication assistant (TMA)-A stated that R53's monitoring alarm was supposed to be placed on the bed near the wall, otherwise if R53 attempted to get out of bed the alarm would not sound. After review of the Kardex dated 10/29/16, TMA-A stated that it would be important for the care plan to reflect where to place the monitoring alarm. During interview on 11/10/16, at 9:40 a.m. registered nurse (RN)-A that following the post fall review any new interventions assessed to be appropriate are then added to the care plan. RN-A further stated that a Kardex that is linked to the care plan is then printed for the nursing assistants to follow. RN-A stated that prior to the fall on 10/18/16, R53 did have a monitoring alarm and that during the fall it did not sound. RN-A stated the intervention was to place the monitoring alarm on the bed near the wall. RN-A further stated that the care plan was not updated to reflect the placement of the monitoring alarm. During interview on 11/10/16, at 10:02 a.m. the director of nursing (DON) stated the monitoring alarm should have been placed near the wall and that the care plan should have been updated to reflect the location the monitoring alarm should be placed, as it was important to attempt to prevent further falls from bed. The facility Resident Incident/Accident policy revised 12/14, directed staff to complete a post fall assessment and identify a root cause, if possible, and prevent future recurrences of a similar type of incident. The policy also directed	2 830		

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2 830	Continued From page 11 staff to determine changes to the plan of care as indicated. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop policies and procedures regarding assessing and monitoring accidents to ensure interventions are in place. The DON or designee could educate staff on the policies and procedures. The DON or designee could develop a monitoring system to ensure residents receive the appropriate care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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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		

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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 November 7th -10th, 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. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or	2 265		

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2 265	Continued From page 3 E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to promptly notify the physician regarding abnormal vital signs for 1 of 1 residents (R21) who experienced hypotension (low blood pressures). Findings Include: R21's admission Minimum Data Set, dated 7/1/16, indicated a moderate cognitive impairment and a diagnosis of hypertension (high blood pressure). Hospital admission, progress, and discharge records, dated 6/23/16 to 6/28/16, indicated R21 was treated for sepsis (blood infection) and identified additional diagnosis including superventricular tachycardia (rapid heartbeat) and heart murmur. Further review of the hospital records indicated the following blood pressures (BP) for R2: (normal BP range is between 140/90 and 90/50) - On 6/23/16, BP was 116/61 millimeters of mercury (mmHg). - On 6/24/16, BP was 117/50 mmHg. - On 6/25/16, BP was 126/36 mmHg. - On 6/26/16, BP was 134/45 mmHg. - On 6/27/16, BP was 140/41 mmHg. - On 6/28/16, BP was 100/31 mmHg. Review of facility document entitled Weights and Vitals Summary identified R21's BP reading as follows:	2 265		

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	00109	A. BUILDING: _____ B. WING _____	11/10/2016

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2 265	Continued From page 4 - On 6/28/16, at 1:00 p.m. BP was 108/59 mmHg. - On 6/29/16, at 9:30 a.m. BP was 84/51 mmHg. - On 6/30/16, at 8:41 p.m. BP was 85/54 mmHg. - On 7/1/16, at 1:29 p.m. BP was 81/43 mmHg. - On 7/1/16, at 8:02 p.m. BP was 84/47 mmHg. There was no indication in R21's medical record that the primary physician had been notified of the hypotension. During interview on 11/10/16, beginning at 9:18 a.m. registered nurse (RN)-A stated R21's BP's were "A little low," but thought they were low with similar values during R21's hospital admission. However, R21's BP had dropped over 20 mmHg below her previous readings. RN-A stated R21 was always lying in bed during the BP readings contributing to the hypotension. RN-A further stated the physician would be notified of values outside the normal for the resident. During interview on 11/10/16, at 12:02 p.m. physician (MD)-A stated he had not visited R21 since her admission to the facility, he had received a fax notification on 6/30/16 regarding R21's mood state, but that he was not notified of R21's blood pressures. MD-A further stated if the BP dropped more than 20 mmHg, he would have altered R21's plan of care by holding BP medications or provided parameters. Nursing progress notes dated 7-2-16, indicated R21 passed away in the morning of 7-2-16. A facility policy entitled Physician Notification- RN on Call, dated 12/17/07, directed staff to notify the physician of significant changes or when there is a need to significantly alter treatment.	2 265		

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2 265	Continued From page 5 SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures, conduct audits related to Notification of Change in residents health to ensure practioners are notified of changes in residents condition accurately. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed 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. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan to include new fall interventions assessed to be implemented following a fall for 1 of 3 residents (R53) reviewed for falls.	2 555		

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2 555	Continued From page 6 Findings include: R53's annual Minimum Data Set (MDS) dated 10/13/16, indicated R53 had severe cognitive impairment and needed extensive assistance with transfers. R53's MDS included a diagnosis of Alzheimer's disease. R53's Post Fall Review dated 10/21/16, indicated R53 had a fall from bed on 10/19/16. The review indicated that the monitoring alarm did not activate when R53 attempted to get out of bed as the alarm was placed to the outside of the bed. The review indicated the care plan was revised to include that the monitoring device was placed on the bed closer to the wall, so that the alarm would activate, notifying staff that R53 was up and moving. R53's care plan dated 10/29/16, directed staff that R53 utilized a TABS alarm (monitoring alarm) in bed to alert staff to R53's self transfer attempts. The care plan did not indicate where the alarm should be placed on R53's bed. During observation on 11/10/16, at 9:09 a.m. R53 was sleeping on the right side facing the wall, the bed was in a low position and a fall matt was on the floor to the outside of the bed. A monitoring alarm was observed to be attached to the bed near the outside of the bed, rather than closer to the wall as specified in the Post Fall Review, with the string attached to R53's shirt. During interview on 11/10/16, at 9:16 a.m. nursing assistant (NA)-A stated that she was not aware that the monitoring alarm was to be placed on the bed near the wall. NA-A stated that fall interventions are verbalized in report and then the	2 555		

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2 555	Continued From page 7	2 555		

care plan is updated and the nurse would print out a new Kardex (tool to direct care) for the nursing assistants to follow. NA-A observed the Kardex in R53's room dated 10/29/16, and stated the Kardex did not direct the staff to where to place the monitoring alarm.

During interview on 11/10/16, at 9:24 a.m. trained medication assistant (TMA)-A stated that it would be important for the care plan to reflect where to place the monitoring alarm.

During interview on 11/10/16, at 9:40 a.m. registered nurse (RN)-A stated that the care plan was not updated following R53's fall indicating where the monitoring alarm should be placed.

During interview on 11/10/16, at 10:02 a.m. the director of nursing stated that the care plan should have been updated to reflect the location of where the monitoring alarm should be placed, as it was important to attempt to prevent further falls from bed.

The undated facility policy Care Plans, Nursing indicated the nursing supervisor was responsible to ensure that the care plan was accurate and timely.

SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is revised and followed. The DON or designee could develop a system to educate staff and a monitoring system to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty-one

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2 555	Continued From page 8 (21) days.	2 555		
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 implement assessed fall interventions for 1 of 3 residents (R53) reviewed for falls. Findings include: R53's annual Minimum Data Set (MDS) dated 10/13/16, indicated R53 had severe cognitive impairment and needed extensive assistance with transfers. R53's MDS included a diagnosis of Alzheimer's disease. R53's falls Care Area Assessment (CAA) dated 10/27/16, indicated R53 was at risk to fall due to altered cognition, wandering, intermittent restlessness, incontinence and the use of	2 830		

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2 830	Continued From page 9	2 830		

psychotropic (mood altering) medications. The CAA indicated a goal for R53 to avoid complications and minimize the risk of falling.

R53's Post Fall Review dated 10/21/16, indicated R53 had a fall from bed on 10/19/16, the review indicated that the monitoring alarm did not activate when R53 attempted to get out of bed as the alarm was placed to the outside of the bed. The review indicated the care plan was revised to include that the monitoring device was placed on the bed closer to the wall, so that the alarm would activate, notifying staff that R53 was up and moving.

R53's care plan dated 10/29/16, directed staff that R53 utilized a tabs alarm (monitoring alarm) in bed to alert staff to R53's self transfer attempts. The care plan did not indicate where the alarm should be placed on R53's bed.

During observation on 11/10/16, at 9:09 a.m. R53 was sleeping on her right side facing the wall, the bed was in a low position and a fall matt was on the floor to the outside of the bed. A monitoring alarm was observed to be attached to the bed near the outside of the bed, rather than closer to the wall as indicated on the Post Fall Review, with the string attached to R53's shirt.

During interview on 11/10/16, at 9:16 a.m. nursing assistant (NA)-A stated that R53's alarm was on the outside of the bed. NA-A stated that she was not aware that the monitoring alarm was to be placed on the bed near the wall. NA-A stated that fall interventions are verbalized in report and then the care plan is updated and the nurse would print out a new Kardex (tool to direct care) for the aids to follow. NA-A observed the Kardex in R53's room dated 10/29/16, and stated the Kardex did

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2 830	Continued From page 10	2 830		

not direct the staff where to place the monitoring alarm.

During interview on 11/10/16, at 9:24 a.m. trained medication assistant (TMA)-A stated that R53's monitoring alarm was supposed to be placed on the bed near the wall, otherwise if R53 attempted to get out of bed the alarm would not sound. After review of the Kardex dated 10/29/16, TMA-A stated that it would be important for the care plan to reflect where to place the monitoring alarm.

During interview on 11/10/16, at 9:40 a.m. registered nurse (RN)-A that following the post fall review any new interventions assessed to be appropriate are then added to the care plan. RN-A further stated that a Kardex that is linked to the care plan is then printed for the nursing assistants to follow. RN-A stated that prior to the fall on 10/18/16, R53 did have a monitoring alarm and that during the fall it did not sound. RN-A stated the intervention was to place the monitoring alarm on the bed near the wall. RN-A further stated that the care plan was not updated to reflect the placement of the monitoring alarm.

During interview on 11/10/16, at 10:02 a.m. the director of nursing (DON) stated the monitoring alarm should have been placed near the wall and that the care plan should have been updated to reflect the location the monitoring alarm should be placed, as it was important to attempt to prevent further falls from bed.

The facility Resident Incident/Accident policy revised 12/14, directed staff to complete a post fall assessment and identify a root cause, if possible, and prevent future recurrences of a similar type of incident. The policy also directed

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2 830	Continued From page 11 staff to determine changes to the plan of care as indicated. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop policies and procedures regarding assessing and monitoring accidents to ensure interventions are in place. The DON or designee could educate staff on the policies and procedures. The DON or designee could develop a monitoring system to ensure residents receive the appropriate care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		