CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: HPRV

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

PAR	Γ I - TO BE COMPLETED BY T	HE STAT	TATE SURVEY AGENCY Facility ID: 00109		
MEDICARE/MEDICAID PROVIDER NO. (L1) 245465 2.STATE VENDOR OR MEDICAID NO. (L2) 668340100	3. NAME AND ADDRESS OF FACILI (L3) COMMUNITY MEMORIAL (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	
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIER CATEGOR 01 Hospital 05 HHA	Y 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint	
6. DATE OF SURVEY 12/29/2016 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other	02 SNF/NF/Dual 06 PRTF 03 SNF/NF/Distinct 07 X-Ray 04 SNF 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 06/30	
11LTC 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 Wain	n	And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code:	6. Scope of Services Limit 7. Medical Director	
18 SNF 18/19 SNF 19 SNF 45 (L37) (L38) (L39)	ICF IID (L42) (L43)		1861 (e) (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE Facility's request for a continuing 17. SURVEYOR SIGNATURE Kathy Lucas, Unit Supervisor	g waiver involving K52	18. STATE SURVEY AGENCY AP Kate JohnsTon, Pro	ogram Specialist 01/26/2017 (L20)		
19. DETERMINATION OF ELIGIBILITY _X 1. Facility is Eligible to Participate 2. Facility is not Eligible (L21)	20. COMPLIANCE WITH C RIGHTS ACT:		21. 1. Statement of Finance		
22. ORIGINAL DATE OF PARTICIPATION 04/01/1987 (L24) (L41)	DATE ENDING DAT (L25)		26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination	05-Fail to Meet Health/Safety 06-Fail to Meet Agreement	
25. LTC EXTENSION DATE: 27. ALTERNATIV A. Suspension (L27) B. Rescind Su	of Admissions: (L44)		04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active	
28. TERMINATION DATE: 2 (L28)	0. INTERMEDIARY/CARRIER NO.	(L31)	30. REMARKS		
31. RO RECEIPT OF CMS-1539 3 (L32)	2. DETERMINATION OF APPROVAL DA 01/13/2017	TE (L33)	Posted 02/01/2017 Co. DETERMINATION APPRO	VAL	



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.

Community Memorial Home January 26, 2017 Page 2

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

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

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered 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.

Community Memorial Home January 26, 2017 Page 2

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

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

Enclosure

cc: Licensing and Certification File

		POST	-CERT	TIFICATION	N REV	ISIT RE	EPORT	•			
IDENTIFIC	R / SUPPLIER / CLIA / CATION NUMBER	MULTIPLE CONS A. Building B. Wing	TRUCTION						DATE 0	F REVISI	Т
245465	Y	1 B. Willig						Y2	12/29/2		Y3
	FACILITY					ADDRESS, CIT	,	CODE			
COMMU	NITY MEMORIAL HOME	=				T MAIN STREE	T				
				<u> </u>	USAKIS,	MN 56360					
program, corrected provision	ort is completed by a qua- to show those deficienced and the date such corre- number and the identified by report form).	ies previously repo ective action was a	orted on the accomplishe	CMS-2567, Statem d. Each deficiency	nent of De	ficiencies and fully identifie	Plan of Cored using eith	rection, that have er the regulation or	LSC		
ITE	M	DATE	ITEM			DATE	ITEM			DATE	
Y4		Y5	Y4			Y5	Y4			Y5	
ID Prefix	F0157	Correction	ID Prefix	F0280	(Correction	ID Prefix	F0323		Correct	tion
Reg. #	483.10(b)(11)	Completed	Reg. #	483.20(d)(3), 483.10 (2))(k) (Completed	Reg.#	483.25(h)		Comple	eted
LSC		12/20/2016	LSC		1	12/20/2016	LSC			12/20/20	016
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	R / SUPPLIER / C							DATE O	F REVISIT
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NAME OF	NITY MEMORIA	I HOME		I .	FREET ADDRESS, CIT		CODE		
COMMO	WITT WILWORK	LITOME			SAKIS, MN 56360	•			
				<u> </u>	·				
		by a qualified State survey reficiencies previously repo							
		ich corrective action was a							
•		identification prefix code	previously shown o	n the CMS-256	67 (prefix codes show	vn to the left	of each requirem	nent on	
tne surve	y report form).								
ITE	М	DATE	ITEM		DATE	ITEM			DATE
Y4		Y5	Y4		Y5	Y4			Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	NFPA	101	Completed	Dog #	NFPA 101		Completed
Neg. #		Completed	Reg. #		Completed	Reg. #			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			
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STATE AC		(INITIALS) TL/KJ	01/26/2017			36536			/04/2017
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FOLLOW	JP TO SURVEY C	OMPLETED ON	☐ CHECK FOR	ANY UNCORRE	ECTED DEFICIENCIES	S. WAS A SUM	IMARY OF	1	
11/10/20					CIES (CMS-2567) SEN				s \square NO

11/10/2016

YES NO

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: HPRV

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

		PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY	AGENCY		Facility ID: 00109
1. MEDICARE/MEDICAID PR (L1) 245465 2.STATE VENDOR OR MEDIC (L2) 668340100			3. NAME AND ADI (L3) COMMUNIT (L4) 410 WEST M (L5) OSAKIS, MN	TY MEMORIAL IAIN STREET			(L6) 56360	4. TYPE OF ACTIO 1. Initial 3. Termination 5. Validation	N: <u>2 (L8)</u> 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANG (L9)	GE OF OWNERSHIP		7. PROVIDER/SUF	PPLIER CATEGORY	Y 09 ESRD	02 13 PTIP	(L7) 22 CLIA	7. On-Site Visit 8. Full Survey After	9. Other Complaint
DATE OF SURVEY ACCREDITATION STATUS Unaccredited AOA	11/10/2016 :: 1 TJC 3 Other	(L34) - (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPIG	CE	FISCAL YEAR ENDIN	NG DATE: (L35)
11. LTC PERIOD OF CERTIFICE From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREE 18 SNF 1 (L37)	45 45	(L18) (L17) 19 SNF (L39)	X B. Not in Com	nce With quirements	1	2345. * Code:	Technical Personnel 24 Hour RN 7-Day RN (Rural SNF) Life Safety Code B*	Following Requirements: 6. Scope of Sc 7. Medical Di 8. Patient Roo 9. Beds/Room (L12)	ervices Limit rector m Size
16. STATE SURVEY AGENCY		PLICABLE S		ATION DATE):		10. CTL/TT	OVENTE V A CENTOV AND	DROVA .	
17. SURVEYOR SIGNATURE Annette Tru		HFE N	Date :	12/08/2016	(L19)		SURVEY AGENCY APP JohnsTon, Pr	ogram Special	Date: 11st 01/13/2017 (L20)
	PAR	Г II - ТО	BE COMPLETE	D BY HCFA RE	EGIONAL	OFFICE (OR SINGLE STAT	E AGENCY	
19. DETERMINATION OF EL 1. Facility is Eli 2. Facility is no	gible to Participate	(L21)		IPLIANCE WITH C	IVIL	21.		al Solveney (HCFA-2572) nterest Disclosure Stmt (HC	CFA-1513)
22. ORIGINAL DATE OF PARTICIPATION 04/01/1987 (L24)	В	C AGREEMI EGINNING : 41)		24. LTC AGREEME ENDING DATI (L25)		VOLUNTAL 01-Merger, 0 02-Dissatisfa		05-Fail to	(L30) NTARY Meet Health/Safety Meet Agreement
25. LTC EXTENSION DATE:	A.	Suspension	E SANCTIONS of Admissions: pension Date:	(L44) (L45)			ason for Withdrawal	OTHER 07-Provic 00-Active	der Status Change
28. TERMINATION DATE:		29	. INTERMEDIARY/C	ARRIER NO.		30. REMAR	RKS		
			03001						
	(L28)			(L31)	Emai	led ROCHI AW	K521 01/13/2	2017 Co.
31. RO RECEIPT OF CMS-153)	32	. DETERMINATION (OF APPROVAL DAT	ГЕ	Poste	d 01/13/2017 Co	0.	
	(L32)			(L33)	DETERM	MINATION APPRO	VAL	



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:

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRINTED: 12/08/2016 FORM APPROVED OMB NO. 0938-0391

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245465	B. WING			11/10/2016	
	PROVIDER OR SUPPLIER	ме		4	STREET ADDRESS, CITY, STATE, ZIP CODE 110 WEST MAIN STREET DSAKIS, MN 56360	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
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	page of the CMS-2 submission of the F verification of comp	567 form. Electronic POC will be used as bliance.					
	revisit of your facilit validate that substa regulations has bee your verification.	acceptable POC an on-site by may be conducted to antial compliance with the en attained in accordance with					
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	consult with the resknown, notify the resor an interested far accident involving to injury and has the printervention; a signiphysical, mental, or deterioration in heastatus in either life to clinical complication significantly (i.e., a existing form of treatment); or a decident from the resident from the \$483.12(a). The facility must also and, if known, the resident from the resident from the facility must also and, if known, the resident from the facility must also and, if known, the resident from the facility must also and, if known, the resident from the facility must also and, if known, the resident from the facility must also and, if known, the resident from the facility must also and the facility must also	ediately inform the resident; sident's physician; and if esident's legal representative mily member when there is an he resident which results in cotential for requiring physician ificant change in the resident's resychosocial status (i.e., a alth, mental, or psychosocial threatening conditions or ms); a need to alter treatment need to discontinue an atment due to adverse to commence a new form of cision to transfer or discharge the facility as specified in					
	change in room or specified in §483.1	member when there is a roommate assignment as 5(e)(2); or a change in					0(0) 5.77
LABORATOR'	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE

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

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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245465	B. WING			11/1	10/2016
	PROVIDER OR SUPPLIER NITY MEMORIAL HO	ME		410	EET ADDRESS, CITY, STATE, ZIP CODE WEST MAIN STREET AKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	regulations as specthis section. The facility must rethe address and properties	er Federal or State law or cified in paragraph (b)(1) of ecord and periodically update mone number of the resident's ecor interested family member. NT is not met as evidenced and document review, the emptly notify the physician all vital signs for 1 of 1 residents enced hypotension (low blood elinimum Data Set, dated moderate cognitive diagnosis of hypertension (high elinimum Data Set, indicated R21 elinimum Data Set, dated moderate cognitive elinimum Data Set, dated moderate elinimum Data Set, dated moderate elinimum Data Set, dated moderate elinimum Data Set, elinimum Data Set, dated moderate elinimum Data Set, dated moderate e	F1		F157 R21 was identified to be efforthed by the deficient practice. Facility fair promptly notify the physician regard abnormal vital signs who experience hypotension. R21 passed away on Residents in the facility with a diagonal hypertension or hypotension will be identified. Guidelines will be establifor blood pressure monitoring for bothigh and low pressures. All vital signs and low pressures. All vital signs reviewed and entered into the electronic health record by licensed Any abnormal vital signs noted will checked by licensed nursing staff vital signs and in the physician will be not at elephone if blood pressures are or low as soon as possible if the resist symptomatic. If the resident has abnormal blood pressures and is asymptomatic a fax will be sent to the physician for his review. The facility monitor its performance with audits DON and RN Supervisory Staff dail weeks then bi weekly for 2 weeks at then weekly for four weeks. All Nur Staff will be educated at the Nurses Meeting on December 7th. This will reviewed at the Quality Assurance	illed to ding ced 7/2/16. nosis of e ished oth gns will d staff. be within notified e high sident is by the ly for 2 and sing s	

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245465	B. WING			11/1	10/2016	
	PROVIDER OR SUPPLIER	ΛE		4	TREET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET DSAKIS, MN 56360			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) TAG			PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 157	- On 6/27/16, BP wa- On 6/28/16, BP wa- Review of facility do Vitals Summary ide follows: - On 6/28/16, at 1:0 - On 6/29/16, at 9:3 - On 6/30/16, at 8:4 - On 7/1/16, at 1:29 - On 7/1/16, at 1:29 - On 7/1/16, at 8:02 There was no indicate that the primary phy hypotension. During interview on a.m. registered nurs were "A little low," be similar values durin However, R21's BP below her previous RN-A stated R21 we the BP readings con RN-A further stated notified of values or resident. During interview on physician (MD)-A stated fax notified of values or received a fax notified R21's mood state, it R21's blood pressu BP dropped more the stated for the stated fax notified fa	as 140/41 mmHg. as 100/31 mmHg. becument entitled Weights and ntified R21's BP reading as 0 p.m. BP was 108/59 mmHg. 0 a.m. BP was 84/51 mmHg. 1 p.m. BP was 85/54 mmHg. p.m. BP was 81/43 mmHg. p.m. BP was 84/47 mmHg. ation in R21's medical record vician had been notified of the 11/10/16, beginning at 9:18 see (RN)-A stated R21's BP's but thought they were low with g R21's hospital admission. had dropped over 20 mmHg readings. as always lying in bed during ntributing to the hypotension. the physician would be utside the normal for the 11/10/16, at 12:02 p.m. that he had not visited R21 in to the facility, he had cation on 6/30/16 regarding but that he was not notified of the nan 20 mmHg, he would have of care by holding BP	F1	57	Meeting on December 20, 2016. Corrective Action will be completed December 20, 2016.	by		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		E SURVEY IPLETED
		245465	B. WING _		11/	10/2016
	PROVIDER OR SUPPLIER	ЛЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 157 F 280 SS=D	R21 passed away in A facility policy entity on Call, dated 12/17 physician of significan need to significan 483.20(d)(3), 483.1 PARTICIPATE PLA The resident has the incompetent or other incapacitated under	otes dated 7-2-16, indicated in the morning of 7-2-16. Iled Physician Notification- RN 7/07, directed staff to notify the eant changes or when there is tly alter treatment. O(k)(2) RIGHT TO NNING CARE-REVISE CP e right, unless adjudged	F 15			12/20/16
	within 7 days after to comprehensive assinterdisciplinary teat physician, a register for the resident, and disciplines as deter and, to the extent puther resident, the resident presentatives	d treatment. are plan must be developed the completion of the sessment; prepared by an m, that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs, racticable, the participation of sident's family or the resident's e; and periodically reviewed am of qualified persons after				
	by: Based on observat review, the facility fa include new fall inte	NT is not met as evidenced cion, interview and document ailed to revise the care plan to erventions assessed to be ing a fall for 1 of 3 residents		F280 R53 was identified as being effected by the deficient practice. failed to revise the care plan to increw fall intervention assessed to	Facility clude the	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION NG		E SURVEY IPLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 280	10/13/16, indicate impairment and not transfers. R53's Malzheimer's disease. R53's Post Fall Re R53 had a fall fror indicated that the activate when R53 the alarm was plather eview indicate include that the m the bed closer to tactivate, notifying moving. R53's care plan do that R53 utilized a in bed to alert staff attempts. The care the alarm should be used was in a low pure the floor to the outalarm was observed the wall as specificated buring interview of assistant (NA)-A signal in the string attached.	mum Data Set (MDS) dated d R53 had severe cognitive eeded extensive assistance with IDS included a diagnosis of se. eview dated 10/21/16, indicated in bed on 10/19/16. The review monitoring alarm did not attempted to get out of bed as ced to the outside of the bed. ed the care plan was revised to onitoring device was placed on he wall, so that the alarm would staff that R53 was up and ated 10/29/16, directed staff TABS alarm (monitoring alarm) if to R53's self transfer e plan did not indicate where be placed on R53's bed. In on 11/10/16, at 9:09 a.m. R53 are right side facing the wall, the position and a fall matt was on side of the bed. A monitoring ed to be attached to the bed if the bed, rather than closer to ed in the Post Fall Review, with	F 28	implemented following a fall for R53 s care plan and Kardex wand updated on 11/12/16 to show part placement of the alarm on the bed near the wall. All residents identified fall histories will have plans and kardex s reviewed sure all fall interventions are or plan and kardex. Each resident resident room of those identifies be assessed to make sure all interventions are in place. All fawill be reviewed at daily nursing meetings, Monday thru Friday. Interventions will be entered in Electronic Health Record Care immediately following the imple of the new intervention. The Kaalso be printed at this time and the resident s room. Verbal reupdated care plans will be given nursing staff on duty and upon change. The DON or Designe fall incidents weekly for 12 weeensure that the Resident Care Kardex are updated with new finterventions and that new fall interventions are implemented resident or resident room. All Staff will be educated at the Nu Meeting on December 7th. This reviewed at the Quality Assural Meeting on December 20th 20 Corrective Action will be complibecember 20, 2016.	ras roper residents with their care o make the care and d will also ture falls g stand-up Fall o the Plan mentation rdex will placed into ports of n to all shift e will audit ks to Plan and all with the Nursing rses g will also nce 16.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	ИE		STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360	•	
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F 280	interventions are verificate plan is update out a new Kardex (in nursing assistants to Kardex in R53's root the Kardex in R53's root the Kardex did not oplace the monitorin. During interview on medication assistant be important for the place the monitorin. During interview on registered nurse (R was not updated fowhere the monitorin. During interview on director of nursing is should have been updated.	NA-A stated that fall erbalized in report and then the d and the nurse would print tool to direct care) for the so follow. NA-A observed the om dated 10/29/16, and stated direct the staff to where to g alarm. 11/10/16, at 9:24 a.m. trained at (TMA)-A stated that it would be care plan to reflect where to	F 2	80		
F 323 SS=D	as it was important falls from bed. The undated facility indicated the nursin to ensure that the ctimely. 483.25(h) FREE OF HAZARDS/SUPER The facility must en environment remain as is possible; and	to attempt to prevent further y policy Care Plans, Nursing ng supervisor was responsible hare plan was accurate and	F 3	23		12/20/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	` '	(X3) DATE SURVEY COMPLETED	
		245465	B. WING _	***************************************	11/	10/2016	
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F 323	Continued From pa	ge 6	F 32	23			
	by: Based on observat review, the facility fa fall interventions for reviewed for falls. Findings include: R53's annual Minim 10/13/16, indicated impairment and nee transfers. R53's MD Alzheimer's disease R53's falls Care Are 10/27/16, indicated altered cognition, w restlessness, incon psychotropic (mood CAA indicated a go complications and r R53's Post Fall Rev R53 had a fall from indicated that the m activate when R53 the alarm was place The review indicate include that the moot the bed closer to th activate, notifying si moving.	ea Assessment (CAA) dated R53 was at risk to fall due to andering, intermittent tinence and the use of I altering) medications. The		F323 R53 was affected by the opractice. Facility failed to implen interventions following assessm Facility did not follow accident/in policy. All residents with identified histories will have their care plankardex is reviewed to make sur interventions are on the care plankardex. Each resident and resid of those identified will also be as make sure all interventions are in All future falls will be reviewed an nursing stand-up meetings Mon Friday. Upon updated Kardex be placed in the resident room the staff will implement the new interimmediately. Verbal reports of the updated care plankardex will be all nursing staff during shift char reports. The DON or Designee fall incident interventions weekly weeks to ensure that the Reside Plan and Kardex are updated with interventions and that new fall interventions are implemented we resident or resident room. All Staff will be educated at the Nur Meeting on December 7th. This reviewed at the Quality Assurant Meeting on December 20th 201 Corrective Action will be comple December 20, 2016.	nent fall ent. cident ed fall ns and e all fall in and ent room seessed to n place. t daily day thru eing icensed rvention ne e given to nge will audit for 12 ent Care th new fall with the Nursing ses will also ce 6.		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		E SURVEY MPLETED
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	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360		
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F 323	that R53 utilized a fin bed to alert staff attempts. The care the alarm should be bed was in a low pothe floor to the outs alarm was observenear the outside of the wall as indicate the string attached During interview or assistant (NA)-A state outside of the bout aware that the placed on the bed if all interventions are the care plan is upoprint out a new Karaids to follow. NA-Aroom dated 10/29/not direct the staff valarm. During interview or medication assistant was of the Kardestated that it would to reflect where to puring interview or registered nurse (Formal Parket Staff valarm).	tabs alarm (monitoring alarm) to R53's self transfer plan did not indicate where e placed on R53's bed. on 11/10/16, at 9:09 a.m. R53 or right side facing the wall, the position and a fall matt was on side of the bed. A monitoring d to be attached to the bed the bed, rather than closer to d on the Post Fall Review, with	F 32	3		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	лE		STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360		
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F 323	RN-A further stated the care plan is the assistants to follow fall on 10/18/16, R5 and that during the stated the intervent monitoring alarm or further stated that to reflect the placer. During interview on director of nursing (alarm should have that the care plan s reflect the location is	n added to the care plan. I that a Kardex that is linked to n printed for the nursing RN-A stated that prior to the 3 did have a monitoring alarm fall it did not sound. RN-A ion was to place the n the bed near the wall. RN-A he care plan was not updated ment of the monitoring alarm. 11/10/16, at 10:02 a.m. the (DON) stated the monitoring been placed near the wall and hould have been updated to the monitoring alarm should important to attempt to	F3	23		
F 329 SS=D	revised 12/14, direct fall assessment and possible, and prevestimilar type of incide staff to determine condicated. 483.25(I) DRUG REUNNECESSARY DEACH resident's druunnecessary drugs drug when used in duplicate therapy); without adequate mindications for its us adverse consequer	at Incident/Accident policy cted staff to complete a post didentify a root cause, if ent future recurrences of a ent. The policy also directed hanges to the plan of care as EGIMEN IS FREE FROM RUGS g regimen must be free from and an unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of aces which indicate the dose or discontinued; or any	F 3	29		12/20/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP CO 410 WEST MAIN STREET OSAKIS, MN 56360		
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F 329	resident, the facility who have not used given these drugs therapy is necessa as diagnosed and record; and resider drugs receive grad behavioral interver contraindicated, in drugs.	e reasons above. ehensive assessment of a y must ensure that residents antipsychotic drugs are not unless antipsychotic drug ry to treat a specific condition documented in the clinical ats who use antipsychotic ual dose reductions, and ations, unless clinically an effort to discontinue these	F3	29		
	by: Based on interview facility failed to add medications for 1 or received blood prediuretics (pills to treexperiencing hypotestical properties of the experiencing hypotestical properties of the experience of the experien	NT is not met as evidenced w and document review, the equately monitor cardiovascular of 6 residents (R21) who ssure medications and eat high blood pressure) while tension (low blood pressures). Ilinimum Data Set, dated moderate cognitive diagnosis of hypertension (high progress, and discharge 8/16 to 6/28/16, indicated R21 pais (blood infection) and I diagnosis including chycardia (rapid heartbeat)		F329 R21 was affected by the practice. Facility failed to admonitor cardiovascular med resident who received blood medications and diuretic pills blood pressure when experishypotension or low blood prewas no indication that the proposed away on 7/2/16. Respectively with a diagnosis of hypotension will be identified admission all residents will be signs taken each shift daily to establish a baseline. After signs will be completed wee often per physician order. A will be reviewed and entered electronic health record by liest a signs will be reviewed and entered electronic health record by liest a signs will be reviewed and entered electronic health record by liest and monitorial will be reviewed and entered electronic health record by liest and monitorial will be reviewed and entered electronic health record by liest and monitorial will be reviewed and entered electronic health record by liest and monitorial will be reviewed and entered electronic health record by liest and monitorial will be reviewed and entered electronic health record by liest and monitorial will be reviewed and entered electronic health record by liest and monitorial will be reviewed and entered electronic health record by liest and monitorial will be reviewed and entered electronic health record by liest and monitorial will be reviewed and entered electronic health record by liest and monitorial will be reviewed and entered electronic health record by liest and monitorial will be reviewed and entered electronic health record by liest and monitorial will be reviewed and entered electronic health record by liest and monitorial will be reviewed and entered electronic health record by liest and monitorial will be reviewed and entered electronic health record by liest and monitorial will be reviewed and entered electronic health record by liest and monitorial will be reviewed and entered electronic health record by liest and monitorial will be reviewed and entered electronic health record by liest and monitorial will be reviewed and entered elect	equately ications for a I pressure s to treat high encing essure. There hysician had sion. R21 sidents in the pertension or d. Upon have their vital for three days er that, vital kly or more ull vital signs d into the	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		E SURVEY IPLETED	
		245465	B. WING		11/	10/2016	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 329	records indicated the (BP) for R21: (norm 140/90 and 90/50) - On 6/23/16, BP we mercury (mmHg) On 6/24/16, BP we On 6/25/16, BP we On 6/26/16, BP we On 6/27/16, BP we On 6/28/16, BP we On 6/28/16, BP we Deveryday in the more Lopressor (BP mercuryday in the more Lopressor 200 mercuryday in the more Lopressor 200 mercuryday in the morning. Review of facility devices a conformal co	Further review of the hospital ne following blood pressures nal BP range is between as 116/61 millimeters of as 117/50 mmHg. as 126/36 mmHg. as 134/45 mmHg. as 140/41 mmHg. as 100/31 mmHg. dician orders, dated 6/28/16, ived the following medications: edication) 100 milligrams (mg) rning. g everyday before bed. dication) 20 mg everyday in coument entitled Weights and entified R21's BP readings as 00 p.m. BP was 108/59 mmHg. 10 a.m. BP was 84/51 mmHg. 11 p.m. BP was 81/43 mmHg. 12 p.m. BP was 84/47 mmHg. 13 c.m. BP was 84/47 mmHg. 14 c.m. BP was 84/47 mmHg. 15 c.m. BP was 84/47 mmHg. 16 d.ministration Record (MAR), 17/16, indicated R21 received for Lopressor and Lasix	F 329	Any abnormal vital signs noted checked by licensed nursing sta 30 minutes. The health care probe notified via telephone if blood pressures are high or low with it about all medications the reside receiving as soon as possible if resident is symptomatic. If the has abnormal blood pressures a asymptomatic a fax with an upd list of cardiovascular medication sent to the physician for his revifacility will monitor its performan audits by the DON and RN Suppostaff daily for 2 weeks then bin weeks and then weekly for four Nursing Staff will be educated a Nurses Meeting on December 7 will also reviewed at the Quality Assurance Meeting on December 2016. Corrective Action will be by December 20, 2016.	aff within ovider will of a formation on tis the resident and is ate and a as will be ew. The ace with ervisory eekly for 2 weeks. All the of the control of		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		245465	B. WING			11/·	10/2016
	PROVIDER OR SUPPLIER	ИE		410	EET ADDRESS, CITY, STATE, ZIP CODE WEST MAIN STREET AKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	registered nurse (R "A little low," but the similar values durin However, R21's BP below her previous was always lying in contributing to the r R21 received her se everyday as staff di them. RN-A stated of values outside th further stating phys parameters." During interview on Director of Nursing interdisciplinary tea were similar to her R21's BP's were sta wasn't eating well a updated the physici During interview on physician (MD)-A si since her admission received a fax notif R21's mood state, I of R21's blood pres the BP dropped mo have altered R21's medications or prov R21's intakes were Review of R21's for 6/28/16 to 7/1/16, ic	11/10/16, beginning at 9:18 (N)-A stated R21's BP's were ought they were low with g R21's hospital admission. It had dropped over 20 mmHg readings. RN-A stated R21 bed during the BP readings hypotension. RN-A reported cheduled BP medications of not have parameters to hold the physician would be notified the normal for the resident, icians were "Reluctant to give 11/10/16, at 11:10 a.m. the (DON) stated the m concluded R21's lower BP's hospitalization BP's, indicating able. The DON stated R21 and thought that RN-A had ian. 11/10/16, at 12:02 p.m. tated he had not visited R21 in to the facility, he had ication on 6/30/16 regarding out stated he was not notified issures. MD-A further stated if one than 20 mmHg, he would plan of care by holding BP vided parameters, especially if	F3	229			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	ЛЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD B ED TO THE APPROPRI FICIENCY)			
F 329	meals and often ref Nursing progress n R21 passed away i A facility policy entit on Call, dated 12/1	otes dated 7-2-16, indicated in the morning of 7-2-16. Iled Physician Notification- RN 7/07, directed staff to notify the eant changes or when there is	F 3	29				

75465027

PRINTED: 12/09/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 245465 B. WING 11/10/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **410 WEST MAIN STREET** COMMUNITY MEMORIAL HOME **OSAKIS, MN 56360** (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 **FIRE SAFETY** THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. 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:

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

TITLE

12/07/2016

(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.

	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER COMMUNITY MEMORIAL HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUS FOLLOWING INFO 1. A description of to correct the defice 2. The actual, or properties of the correct the defice 3. The name and/oresponsible for corprevent a reoccurr. This facility was sufferent times constructed in 196 determined to be constructed in 196 determined to 196 determined to be constructed in 196 determined to be construc	state.mn.us n@state.mn.us RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done iency. roposed, completion date. or title of the person rection and monitoring to ence of the deficiency. riveyed as one building. rial Home is a 2 story building. The building was constructed in the building was constructed in the original building was 3, is one story and was of Type II(000) construction. In Type II(000), expansion to the indeed. In 2008 a 2 story was added. all sections are considered surveyed as one building. by fire sprinkler throughout. The larm system that includes in the corridors and spaces or that is monitored for artment notification. The ve battery operated smoke illity has a capacity of 45 beds of 32 at the time of the survey.		000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SU COMPLET		
		245465	B. WING			_11/	10/2016	
	NAME OF PROVIDER OR SUPPLIER COMMUNITY MEMORIAL HOME			4	TREET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET DSAKIS, MN 56360			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 291 SS=E K 321 SS=E	Emergency Lighting is provided automa 18.2.9.1, 19.2.9.1 This STANDARD is Based on observa facility failed to mai accordance with the Safety Code, (NFP deficient practice cability to exit in the could affect and ur residents, staff and Findings include, On the facility tour pm on 11/10/2016 interview revealed Wellness Center face.	g of at least 1-1/2-hour duration attically in accordance with 7.9. Its not met as evidenced by: tions and staff interview the intain emergency lighting in e provisions of the 2012 Life A 101) section 7.9.2. The ould negatively affect the case of a power failure. This adetermined amount of a visitors. between 08:00 am and 12:00 observations and staff the emergency lights in the ailed to operate when tested. lition was confirmed by the mental Services.		291	K291 By 12-20-16 or sooner, the E of Environmental Services will restorautomatic emergency lighThe Direct then, by 12-20-16, inspect all other emergency lights within the wellness center to ensure their operability. The ensure future compliance, the Direct Environmental Services will monito verify through his/her signature that emergency lights within the wellness center are tested and operable on amonthly basis.	ore ctor will ss To ctor of r and t all ss	12/20/16	
	Hazardous areas a having 1-hour fire rated doors) or system in accordar approved automati option is used, the other spaces by sn doors in accordance self-closing or autohave nonrated or fi	are protected by a fire barrier resistance rating (with 3/4-hour an automatic fire extinguishing nce with 8.7.1. When the c fire extinguishing system areas shall be separated from noke resisting partitions and the with 8.4. Doors shall be smatic-closing and permitted to ield-applied protective plates 48 inches from the bottom of						

	OF DEFICIENCIES OF CORRECTION	DECTION IN THE PROPERTY IN THE		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245465	B. WING _		11/10/2016	
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
K 321	hazardous areas the 19.3.2.1 Area Seperation N/A. Boiler and Fuel-19. Laundries (large c. Repair, Maintenard. Soiled Linen Roge. Trash Collection (exceeding 64 gallef. Combustible Sto (over 50 square feeg. Laboratories (if c. Hazard - see K322 This STANDARD Based on observate facility failed to corraccordance with the (NFPA 101) section practice could allow corridor making it c. 24 of the 32 reside amount of staff and Findings include: On the facility tour pm on 11/10/2016 interview revealed converted to soiled equipped with auto-	Automatic Sprinkler A Fired Heater Rooms r than 100 square feet) ance, and Paint Shops oms (exceeding 64 gallons) Rooms ons) rage Rooms/Spaces et) classified as Severe 0) is not met as evidenced by: ition and staff interview the instruct 2 soiled utility rooms in ite 2012 Life Safety Code, in 19.3.2.1.3. This deficient is for smoke or fire to enter the untenable for exiting, affecting ints and an undetermined id visitors. between 08:00 am and 12:00 observations and staff shower rooms 10 and 30 were if utility rooms and were not omatic door closer's.	K 32	K321 By 12-20-16 or sooner, the of Environmental Services will in automatic door closing device of the identified doors to shower round #30. To ensure future compute Director of Environmental School document w/signature that these along with all others in the building operable, functioning as expected achieving a positive latch.	stall an n each of oms #10 bliance, ervices will e closers ng are	
K 363 SS=E	NFPA 101 Corridor Corridor - Doors 2012 EXISTING	r - Doors	K 36	3		12/20/16

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	PLE CONSTRUCTION G 01 - Main Building 01	(X3) DATE SURVEY COMPLETED		
		245465	B. WING		11/10/201	16	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPI	K5) LETION ATE	
K 363	required enclosur hazardous areas as those construct core wood, or car 20 minutes. Door compartments ar passage of smoke means suitable for There is no impedoors. Clearance floor covering is relatches are prohild corridor doors and or combustible more complying with 7 devices that release pulled are permit of unlimited heigh meeting 19.3.6.3 Door frames shader or other materials the smoke compoundow assemblis sprinklered compound with the smoke compound with	corridor openings in other than res of vertical openings, exits, or shall be substantial doors, such cted of 1-3/4 inch solid-bonded pable of resisting fire for at least is in fully sprinklered smoke the endry required to resist the end between shall be provided with a parkeeping the door closed diment to the closing of the between bottom of door and not exceeding 1 inch. Roller bited by CMS regulations on direct rolling flammable staterials. Powered doors 2.1.9 are permissible. Hold open as when the door is pushed or ted. Nonrated protective plates in tare permitted. Dutch doors are permitted. Butch doors are permitted. Butch doors are permitted. Fixed fire the sare allowed per 8.3. In partments there are no tea or fire resistance of glass or		K363 By 12-20-16 or sooner, of Environmental Services will #12 linen closet door located in corridor so that it achieves a pupon being closed. The Direct Environmental Services will that door and all others in the	repair the n the east ositive latch tor of en monitor		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '			(X3) DATE SURVE COMPLETED	
		245465	B. WING			11/10/2016	
	PROVIDER OR SUPPLIER	ME @		4	TREET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET SAKIS, MN 56360		
(X4) ID PREFIX TAG			ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	undetermined amo Findings include: On the facility tour pm on 11/10/2016 interview revealed corridor did not pos This deficient cond Director of Environ NFPA 101 HVAC HVAC Heating, ventilation	the 32 residents and an punt of staff and visitors. between 08:00 am and 12:00 observations and staff the linen closet, #12 in the east sitively latch. lition was confirmed by the mental Services. n, and air conditioning shall d shall be installed in the manufacturer's		521	a monthly basis to ensure that they are operable and achieving a positive latch		12/20/16
	Based on observa was revealed that the aspart of the air displayment of the air displayment of the exhaust, throughout accordance with N practice could allow to travel far from the affect all residents,	is not met as evidenced by: tions and staff interview, it the facility is using the corridors istribution system to provide e sleeping rooms' bathroom ut the building which is not in FPA 90A. This deficient w the products of combustion ne fire origin and negatively staff and visitors by restricting ess in a fire situation			K521 A waiver continuation for K521 been requested for which justification dated 12-5-16 on form CMS 2786R waattached.		
	rinaings include:						
	On the facility tour	between 08:00 am and 12:00					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION - MAIN BUILDING 01	(X3) DAT	TE SURVEY MPLETED	
		245465	B. WING			11.	/10/2016	
	PROVIDER OR SUPPLIER	ME	STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
K 521	interview revealed wings in the 1963 a ducted air supply to baseboard heat in no return air ducts corridor is being us	observations and staff that the HVAC systems for all and 1977 additions have to the corridors and hot water the resident rooms. There are in the resident rooms and the sed as a return plenum. lition was confirmed by the	K	521				

lame of Facility

Community Memorial Home at Osakis, MN Inc. dba Galeon

2000 CODE

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

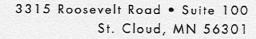
corridors are used as and NFPA 90A, 2012 with LSC Chapter 19 and Air Conditioning Edition because the CMH does not comply K521 (HVAC) equipment at Heating, Ventilation PROVISION NUMBER(S) B. If this waiver is approved, the safety of building occupants will not be compromised because: A continuing waiver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

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

Requested by:

David E. Carlson, Administrator

12-5-2016



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

estor Enel

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

3315 Roosevelt Road, Ste. 100

St. Cloud MN 56301

Bus. (320) 251-0262 Fax: (320) 251-5749

Low Range 24,000 S.F.

High Range 24,000 S.F.

DOLLARS

DOLLARS

I. LAND	SUBTOTAL LAND	\$ 		\$ 	
II. CONSTRUCTION COSTS					
GENERAL CONDITIONS		\$ 28,687	\$ 1.20	\$ 35,774	\$ 1.49
INTERIOR FINISHES / DEMO	0	\$ 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 CONS	TRUCTION COSTS	\$ 348,002	\$ 14.50	\$ 455,680	\$ 18.99
III. SOFT COSTS					-
FEES / PERMITS / PRINTING	3	\$ 70,185	\$ 2.92	\$ 92,703	\$ 3.86
OTHER		\$ -	\$ 	\$ _	\$ _
SUBTO	OTAL SOFT COSTS	\$ 70,185	\$ 2.92	\$ 92,703	\$ 3.86
IV. OWNER ITEMS					
FURNITURE/FIXTURES/EQU	IPMENT	\$ 8		\$ -	
OTHER - ASBESTOS ABATE	MENT	\$ 64,336	\$ 2.68	\$ 90,295	\$ 3.76
SUBTOTAL OWN	NER ITEMS COSTS	\$ 64,336	\$ 2.68	\$ 90,295	\$ 3.76
V. TOTAL PROJECT COST		\$ 482,523	\$ 20.11	\$ 638,677	\$ 26.61



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

Community Memorial Home November 29, 2016 Page 2

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

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00109	B. WING		11/1	0/2016
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
COMMU	NITY MEMORIAL HON	410 WEST	T MAIN STRE			
COMMO	NITT WEWORIAL HON	OSAKIS, I	MN 56360			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTENTION*****					
	NH LICENSING CORRECTION ORDER					
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment 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.					
	that may result from orders provided tha the Department witl	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.com/	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at: state.mn.us/divs/fpc/profinfo/in ate licensing orders are				

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

Electronically Signed 12/07/16

TITLE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00109	B. WING		11/1	0/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
сомми	NITY MEMORIAL HOI	ME	T MAIN STRI MN 56360	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 000	Department of Hea you electronically. is necessary for State necessary for State the word "cortext. You must then State licensure procompletion date, the corrected prior to element on November 7th Department's staff, the following correction that you and identify the dat Minnesota Department of State Licensing federal software. To assigned to Minnesota Department of the State Licensing federal software. To assigned to Minnesota Department of the State Licensing federal software. To assigned to Minnesota Department of the State Licensing federal software. To assigned the minnesota Department of the State Licensing federal software. To satisfied the State Licensing federal software. The assigned tag in column entitled "Illustrature/rule out of column entitled "Illustrature/rule	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. 10th, 2016 surveyors of this visited the above provider and ction orders are issued. Your electronic plan of have reviewed these orders, e when they will be completed. Then to f Health is documenting ag numbers have been sota state statutes/rules for some sota state statutes/rules for comply" portion of the ent of Deficiencies" column to Comply" portion of the nis column also includes the n violation of the state statute, "This Rule is not met as wing the surveyors findings Method of Correction and crection. ARD THE HEADING OF THE	2 000			

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 2 of 12 HPRV11

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00109	B. WING		11/1	0/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
сомми	NITY MEMORIAL HOI	ME	TMAIN STRI MN 56360	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Continued From pa	ige 2	2 000			
	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.					
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status		2 265			12/20/16
	policies to guide sta physicians, physicia practitioners, and if legal representative member of a reside accident, or death. nursing services, a attending physician development of the	ust develop and implement aff decisions to consult an assistants, and nurse known, notify the resident's e or an interested family ent's acute illness, serious. At a minimum, the director of and the medical director or an amust be involved in the use policies. The policies must address at least the tion times for:				
		involving the resident which I has the potential for requiring on;				
	physical, mental, o example, a deterior	change in the resident's or psychosocial status, for ration in health, mental, or in either life-threatening al complications;				
	example, a need to	ter treatment significantly, for discontinue an existing form adverse consequences, or to f treatment;				
	D. a decision tresident from the n	to transfer or discharge the ursing home; or				

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Minnesota Department of Health STATE FORM

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00109	B. WING		11/1	0/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
COMMU	NITY MEMORIAL HON	410 WEST	MAIN STRI	EET		
COMMO	MITT WEWORIAL HON	OSAKIS, I	MN 56360			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 265	Continued From pa	ge 3	2 265			
	E. expected an	d unexpected resident deaths.				
	by:	ent is not met as evidenced				
	facility failed to pror regarding abnormal	and document review, the nptly notify the physician vital signs for 1 of 1 residents ced hypotension (low blood		Corrected		
	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).					
	records, dated 6/23 was treated for sep- identified additional superventricular tac and heart murmur. records indicated the	progress, and discharge /16 to 6/28/16, indicated R21 sis (blood infection) and diagnosis including chycardia (rapid heartbeat) Further review of the hospital se following blood pressures all BP range is between 140/90				
	- On 6/23/16, BP was mercury (mmHg). - On 6/24/16, BP was - On 6/25/16, BP was - On 6/26/16, BP was - On 6/28/16, BP was	as 126/36 mmHg. as 134/45 mmHg. as 140/41 mmHg.				
		ocument entitled Weights and ntified R21's BP reading as				

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PRINTED: 12/08/2016 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00109 11/10/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **410 WEST MAIN STREET COMMUNITY MEMORIAL HOME OSAKIS, MN 56360** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 265 Continued From page 4 2 265 - 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

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medications or provided parameters.

a need to significantly alter treatment.

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

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00109	B. WING		11/1	0/2016	
	PROVIDER OR SUPPLIER	410 WFS	DRESS, CITY, S	STATE, ZIP CODE EET			
COMINIO	NITT WEWORIAL HOI	OSAKIS, I	MN 56360				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
2 265	Continued From pa	age 5	2 265				
	The director of nurs review and revise p conduct audits rela residents health to of changes in resid DON or designee of	THOD FOR CORRECTION: sing (DON) or designee could policies and procedures, ted to Notification of Change in ensure practioners are notified ents condition accurately. The could develop monitoring ongoing compliance.					
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one					
2 555	MN Rule 4658.040 Plan of Care; Deve	5 Subp. 1 Comprehensive lopment	2 555			12/20/16	
	must develop a cor each resident within completion of the c assessment as def comprehensive pla by an interdisciplina attending physician responsibility for the appropriate staff in the resident's need practicable, with the	elopment. A nursing home imprehensive plan of care for in seven days after the omprehensive resident ined in part 4658.0400. The in of care must be developed ary team that includes the interest are a registered nurse with the resident, and other indisciplines as determined by its interest and in the interest and int					
	by: Based on observat review, the facility f include new fall into	ent is not met as evidenced ion, interview and document ailed to revise the care plan to erventions assessed to be ving a fall for 1 of 3 residents falls.		Corrected			

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STATE FORM 6899 HPRV11 If continuation sheet 6 of 12

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00109	B. WING		11/10/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
COMMU	NITY MEMORIAL HO	ME	T MAIN STRE MN 56360	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 555	Continued From pa	ige 6	2 555			
	10/13/16, indicated impairment and net transfers. R53's ME Alzheimer's disease R53's Post Fall Rev R53 had a fall from indicated that the mactivate when R53 the alarm was place. The review indicated include that the mothe bed closer to the	num Data Set (MDS) dated R53 had severe cognitive eded extensive assistance with DS included a diagnosis of e. view dated 10/21/16, indicated bed on 10/19/16. The review nonitoring alarm did not attempted to get out of bed as ed to the outside of the bed. Ed the care plan was revised to nitoring device was placed on e wall, so that the alarm would taff that R53 was up and				
	that R53 utilized a in bed to alert staff attempts. The care the alarm should be During observation was sleeping on the bed was in a low pothe floor to the outs alarm was observenear the outside of the wall as specified the string attached	ted 10/29/16, directed staff TABS alarm (monitoring alarm) to R53's self transfer plan did not indicate where e placed on R53's bed. on 11/10/16, at 9:09 a.m. R53 e right side facing the wall, the osition and a fall matt was on side of the bed. A monitoring d to be attached to the bed the bed, rather than closer to d in the Post Fall Review, with to R53's shirt.				
	assistant (NA)-A stathat the monitoring bed near the wall.	ated that she was not aware alarm was to be placed on the NA-A stated that fall erbalized in report and then the				

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STATE FORM 6899 HPRV11 If continuation sheet 7 of 12

Minnesota Department of Health

STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00109	B. WING		11/1	0/2016
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
COMMUNIT	TY MEMORIAL HON	ME 410 WEST OSAKIS, I	MAIN STRE	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
con Kth p D m b p D m b p D m w w D d s o a fa T in to ti	but a new Kardex (thursing assistants to Kardex in R53's rook he Kardex did not come k	d and the nurse would print cool to direct care) for the ofollow. NA-A observed the om dated 10/29/16, and stated direct the staff to where to g alarm. 11/10/16, at 9:24 a.m. trained at (TMA)-A stated that it would be care plan to reflect where to	2 555			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00109	B. WING		11/1	0/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
COMMU	NITY MEMORIAL HON	1 F	MAIN STRI	EET		
0/0.15	CLIMANA DV CTA	TEMENT OF DEFICIENCIES	MN 56360	PROVIDER'S PLAN OF CORRECTION	ON	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 555	Continued From pa	ge 8	2 555			
	(21) days.					
2 830	MN Rule 4658.0520 Proper Nursing Car	Subp. 1 Adequate and e; General	2 830			12/20/16
	receive nursing cardicustodial care, and individual needs and the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a ne attending physician that the in in bed or the resident bed.				
	by: Based on observatireview, the facility fa	ent is not met as evidenced on, interview and document ailed to implement assessed of 1 of 3 residents (R53)		Corrected.		
	Findings include:					
	10/13/16, indicated impairment and nee	num Data Set (MDS) dated R53 had severe cognitive eded extensive assistance with DS included a diagnosis of e.				
	10/27/16, indicated altered cognition, w	ea Assessment (CAA) dated R53 was at risk to fall due to andering, intermittent tinence and the use of				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00109	B. WING		11/1	0/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
сомми	NITY MEMORIAL HO	ИF	MAIN STRE	EET		
(VA) ID	SLIMMA DV STA	TEMENT OF DEFICIENCIES	MN 56360	PROVIDER'S PLAN OF CORRECTION	- NI	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 9	2 830			
	psychotropic (mood altering) medications. The CAA indicated a goal for R53 to avoid complications and minimize the risk of falling.					
	R53 had a fall from indicated that the mactivate when R53 the alarm was place. The review indicate include that the mothe bed closer to the	view dated 10/21/16, indicated bed on 10/19/16, the review nonitoring alarm did not attempted to get out of bed as ed to the outside of the bed. Ed the care plan was revised to nitoring device was placed on e wall, so that the alarm would taff that R53 was up and				
	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.					
	was sleeping on he bed was in a low po the floor to the outs alarm was observe near the outside of	on 11/10/16, at 9:09 a.m. R53 r right side facing the wall, the esition and a fall matt was on ide of the bed. A monitoring d to be attached to the bed the bed, rather than closer to d on the Post Fall Review, with to R53's shirt.				
	assistant (NA)-A stathe outside of the broad not aware that the replaced on the bed refall interventions are the care plan is upoprint out a new Karaids to follow. NA-A	11/10/16, at 9:16 a.m. nursing ated that R53's alarm was on ed. NA-A stated that she was monitoring alarm was to be near the wall. NA-A stated that e verbalized in report and then dated and the nurse would dex (tool to direct care) for the cobserved the Kardex in R53's 6, and stated the Kardex did				

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Minnesota Department of Health

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00109	B. WING		11/10/2016	
NAME OF PF	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
COMMUN	ITY MEMORIAL HON	Λ Ε	MAIN STRI	EET		
0(0.15	CLIMMA DV CTA	·	MN 56360	DDOVIDEDIS DI ANI OF CODDECTI	ON	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 10	2 830			
	not direct the staff v alarm.	where to place the monitoring				
	medication assistar monitoring alarm wathe bed near the wathe bed near the wathe get out of bed the review of the Karde stated that it would to reflect where to puring interview on registered nurse (Roreview any new interpropriate are the RN-A further stated the care plan is the assistants to follow. If all on 10/18/16, R5 and that during the stated the interventimonitoring alarm or further stated that the care plan of further stated that the oreflect the placent During interview on director of nursing (alarm should have be that the care plan significant to placed, as it was prevent further falls. The facility Resident revised 12/14, directal assessment and	11/10/16, at 9:24 a.m. trained at (TMA)-A stated that R53's as supposed to be placed on all, otherwise if R53 attempted a alarm would not sound. After x dated 10/29/16, TMA-A be important for the care plan place the monitoring alarm. 11/10/16, at 9:40 a.m. N)-A that following the post fall erventions assessed to be an added to the care plan. That a Kardex that is linked to a printed for the nursing. RN-A stated that prior to the 3 did have a monitoring alarm fall it did not sound. RN-A ion was to place the an the bed near the wall. RN-A he care plan was not updated ment of the monitoring alarm. 11/10/16, at 10:02 a.m. the DON) stated the monitoring alarm. 11/10/16, at 10:02 a.m. the DON) stated the monitoring alarm should have been updated to the monitoring alarm should in important to attempt to from bed.				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	COMPLETED		
		00109	B. WING		11/1	0/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
сомми	NITY MEMORIAL HO	Λ Ε	T MAIN STRI MN 56360	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	staff to determine condicated. SUGGESTED MET The director of nursidevelop policies an assessing and moninterventions are in could educate staff procedures. The Didevelop a monitoring receive the appropriate individuals and the staff procedures are in the could educate staff procedures.	hanges to the plan of care as THOD FOR CORRECTION: sing (DON) or designee could d procedures regarding litoring accidents to ensure place. The DON or designee on the policies and ON or designee could ng system to ensure residents	2 830	DEFICIENCY)		

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00109	B. WING		11/10/2016
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	E, ZIP CODE	
COMMUN	ITY MEMORIAL HOME		T MAIN STREET MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
2 000	Initial Comments		2 000		
	****ATTEN	TION*****			
	NH LICENSING CO	ORRECTION ORDER			
	144A.10, this correction pursuant to a survey. Found that the deficier herein are not correct not corrected shall be with a schedule of fine the Minnesota Depart. Determination of where corrected requires controlled requires controlled when a rule contains comply with any of the lack of compliance. Line-inspection with any result in the assessment.	ther a violation has been mpliance with all			
	corrected. You may request a he that may result from norders provided that a the Department within notice of assessment INITIAL COMMENTS: You have agreed to preceipt of State licens the Minnesota Depart Informational Bulletin	earing on any assessments and compliance with these a written request is made to a 15 days of receipt of a for non-compliance. : articipate in the electronic ure orders consistent with ment of Health 14-01, available at: ate.mn.us/divs/fpc/profinfo/in the licensing orders are			

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

(X6) DATE TITLE

Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00109	B. WING		11	/10/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STATE	, ZIP CODE		
COMMUN	ITY MEMORIAL HOME		T MAIN STREET MN 56360			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
2 000	Department of Health you electronically. Al is necessary for State enter the word "correct text. You must then in State licensure proce completion date, the corrected prior to elect Minnesota Department." On November 7th -10 Department's staff, vithe following correction Please indicate in you correction that you have and identify the date of Minnesota Department the State Licensing Confederal software. Tag assigned to Minnesota Nursing Homes. The assigned tag nur column entitled "ID I statute/rule out of con "Summary Statement and replaces the "To correction order. This findings which are in after the statement, "evidence by." Following are the Suggested McTime period for Correction Correctio	orders being submitted to though no plan of correction a Statutes/Rules, please cted" in the box available for idicate in the electronic iss, under the heading date your orders will be ctronically submitting to the int of Health. Oth, 2016 surveyors of this issted the above provider and on orders are issued. It electronic plan of invereviewed these orders, when they will be completed. Int of Health is documenting orrection Orders using numbers have been a state statutes/rules for in the information of the column also includes the violation of the state statute. This Rule is not met as ing the surveyors findings ethod of Correction and ction. Difference is in the the information of the state statute. This Rule is not met as ing the surveyors findings ethod of Correction and ction. Difference is in the the information of the state statute. This Rule is not met as ing the surveyors findings ethod of Correction and ction. Difference is in the state in the information of the state statute. This Rule is not met as ing the surveyors findings ethod of Correction and ction. Difference is in the information of the information of the state statute. This Rule is not met as ing the surveyors findings ethod of Correction and ction. Difference is in the information of the information of the state statute. This Rule is not met as ing the surveyors findings ethod of Correction and ction.	2 000			

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	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	2) MULTIPLE CONSTRUCTION (X3) DATE COMP	
		00109	B. WING		11/10/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE	
COMMUN	ITY MEMORIAL HOME		ST MAIN STREET , MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
2 000	Continued From page	2	2 000		
		IREMENT TO SUBMIT A ION FOR VIOLATIONS OF STATUTES/RULES.			
2 265	MN Rule 4658.0085 N Resident Health Statu	_	2 265		
	policies to guide staff physicians, physician practitioners, and if kr legal representative o member of a resident accident, or death. A nursing services, and attending physician m	assistants, and nurse nown, notify the resident's r an interested family s acute illness, serious t a minimum, the director of the medical director or an oust be involved in the policies. The policies must ldress at least the			
		olving the resident which as the potential for requiring;			
	physical, mental, or periodic example, a deterioration	nange in the resident's psychosocial status, for ion in health, mental, or a either life-threatening complications;			
	example, a need to di	treatment significantly, for scontinue an existing form dverse consequences, or to reatment;			
	D. a decision to resident from the nurs	transfer or discharge the sing home; or			

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	a Department of Fleatt				T	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAIN (J. GORREGION	DENTILICATION NUMBER.	A. BUILDING: _		COIVIPL	- 1.20
		00109	B. WING		11/1	0/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE		
			Γ MAIN STREET	,		
COMMUN	ITY MEMORIAL HOME		MN 56360			
()(4) ID	STIMMADV STA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	NI	(75)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				DETIGIENCY)		
2 265	Continued From page 3		2 265			
	E expected and unexpected resident deaths					
	E. expected and unexpected resident deaths.					
	This MN Requirement	t is not met as evidenced				
	by:					
		nd document review, the				
		otly notify the physician				
		ital signs for 1 of 1 residents				
	· / '	ed hypotension (low blood				
	pressures).					
	Findings Include:					
	agoo.aao.					
	R21's admission Mini	mum Data Set, dated				
	7/1/16, indicated a mo	oderate cognitive				
	-	gnosis of hypertension (high				
	blood pressure).					
		rogress, and discharge 6 to 6/28/16, indicated R21				
	was treated for sepsis					
	identified additional di	,				
		/cardia (rapid heartbeat)				
		irther review of the hospital				
	records indicated the	following blood pressures				
		3P range is between 140/90				
	and 90/50)					
	On 6/22/46 DD	116/61 millimaters of				
	 On 6/23/16, BP was mercury (mmHg). 	110/01 millimeters of				
	- On 6/24/16, BP was	117/50 mmHa.				
	- On 6/25/16, BP was	<u>o</u>				
	- On 6/26/16, BP was					
	- On 6/27/16, BP was	<u> </u>				
	- On 6/28/16, BP was	100/31 mmHg.				
	_	ument entitled Weights and				
	•	ified R21's BP reading as				
	follows:					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S COMPL		
			7 202				
		00109	B. WING		11/1	0/2016	
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE			
COMMUNI	TY MEMORIAL HOME	410 WEST OSAKIS, N	MAIN STREET	•			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 265	- On 6/29/16, at 9:30 - On 6/30/16, at 8:41 - On 7/1/16, at 1:29 p - On 7/1/16, at 1:29 p - On 7/1/16, at 8:02 p There was no indication that the primary physical hypotension. During interview on 1 a.m. registered nurse were "A little low," but similar values during the However, R21's BP helow her previous re RN-A stated R21 was the BP readings contre RN-A further stated the notified of values outs resident. During interview on 1 physician (MD)-A state since her admission to received a fax notificate R21's mood state, but R21's blood pressures BP dropped more that altered R21's plan of medications or provid Nursing progress note R21 passed away in the A facility policy entitle on Call, dated 12/17/0	p.m. BP was 108/59 mmHg. a.m. BP was 84/51 mmHg. p.m. BP was 85/54 mmHg. m. BP was 81/43 mmHg. m. BP was 84/47	2 265				

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00109	B. WING		11/10/2016
NAME OF D	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	E ZIR CODE	1111012010
NAME OF F	ROVIDER OR SUFFLIER		T MAIN STREET	E, ZIF CODE	
COMMUN	ITY MEMORIAL HOME		MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
2 265	Continued From page	5	2 265		
2 555	The director of nursing review and revise policonduct audits related residents health to en of changes in resident DON or designee cousystems to ensure on TIME PERIOD FOR 0 (21) days. MN Rule 4658.0405 S	It to Notification of Change in sure practioners are notified its condition accurately. The lid develop monitoring going compliance. CORRECTION: Twenty-one	2 555		
	Plan of Care; Develor				
	must develop a compleach resident within sompletion of the completion of the comprehensive plan comprehensive plan of by an interdisciplinary attending physician, a responsibility for the rappropriate staff in distinct the resident's needs,	prehensive resident and in part 4658.0400. The after care must be developed at team that includes the a registered nurse with a resident, and other acciplines as determined by and, to the extent articipation of the resident,			
	by: Based on observation review, the facility fail-include new fall interv	t is not met as evidenced i, interview and document ed to revise the care plan to entions assessed to be g a fall for 1 of 3 residents ls.			

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Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
7,110 1 27,111	or definition	IDEKTII IOMITOMIDEK.	A. BUILDING: _		JOHN EETES	
		00109	B. WING		11/10/2016	3
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
COMMUN	ITY MEMORIAL HOME		MAIN STREET	ī		
	OUR MADY OF	OSAKIS, N		200//2500 21 44 05 000050710		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMP	
2 555	5 Continued From page 6		2 555			
	Findings include:					
	10/13/16, indicated R impairment and need	m Data Set (MDS) dated 53 had severe cognitive ed extensive assistance with included a diagnosis of				
	R53 had a fall from be indicated that the more activate when R53 at the alarm was placed. The review indicated include that the monit the bed closer to the second control of th	w dated 10/21/16, indicated ed on 10/19/16. The review nitoring alarm did not tempted to get out of bed as to the outside of the bed. the care plan was revised to oring device was placed on wall, so that the alarm would ff that R53 was up and				
	that R53 utilized a TA in bed to alert staff to	an did not indicate where				
	was sleeping on the r bed was in a low posi the floor to the outside alarm was observed t near the outside of the	ight side facing the wall, the tion and a fall matt was on e of the bed. A monitoring o be attached to the bed e bed, rather than closer to n the Post Fall Review, with R53's shirt.				
	assistant (NA)-A state that the monitoring al- bed near the wall. NA	1/10/16, at 9:16 a.m. nursing ed that she was not aware arm was to be placed on the A-A stated that fall palized in report and then the				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		00109	B. WING		11	1/10/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
COMMUN	IITY MEMORIAL HOME		ST MAIN STREET , MN 56360			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 555	care plan is updated out a new Kardex (to nursing assistants to Kardex in R53's room the Kardex did not did place the monitoring. During interview on 1 medication assistant be important for the coplace the monitoring. During interview on 1 registered nurse (RN was not updated followhere the monitoring.) During interview on 1 director of nursing standard have been up of where the monitorias it was important to falls from bed. The undated facility principated the nursing to ensure that the cartimely. SUGGESTED METH The director of nursing review and revise porto ensuring the care president is revised and designee could devel and a monitoring syscompliance.	and the nurse would print of to direct care) for the follow. NA-A observed the n dated 10/29/16, and stated rect the staff to where to alarm. 11/10/16, at 9:24 a.m. trained (TMA)-A stated that it would care plan to reflect where to alarm.	2 555			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00400	B. WING		44/40/0046	
NAME OF P	ROVIDER OR SUPPLIER	00109 STREET ADD	RESS, CITY, STA	TE ZIP CODE	11/10/2016	
	ITY MEMORIAL HOME	410 WEST	MAIN STREET			
		OSAKIS, M	N 56360			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
2 555	Continued From page	e 8	2 555			
	(21) days.					
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General		2 830			
	receive nursing care a custodial care, and su individual needs and the comprehensive replan of care as descr 4658.0405. A nursing of bed as much as po	preferences as identified in esident assessment and libed in parts 4658.0400 and ghome resident must be out essible unless there is a attending physician that the in bed or the resident				
	by: Based on observation	t is not met as evidenced n, interview and document ed to implement assessed of 3 residents (R53)				
	Findings include:					
	10/13/16, indicated Rimpairment and need	m Data Set (MDS) dated 53 had severe cognitive ed extensive assistance with included a diagnosis of				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE S COMPL		E SURVEY PLETED	
		00109	B. WING		11	/10/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
COMMUN	IITY MEMORIAL HOME	410 WES	T MAIN STREET			
COMMON	ITT MEMORIAL HOME	OSAKIS,	MN 56360			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 830	psychotropic (mood a CAA indicated a goal complications and min R53's Post Fall Revier R53 had a fall from beindicated that the moractivate when R53 at the alarm was placed The review indicated include that the monit the bed closer to the activate, notifying star moving. R53's care plan dated that R53 utilized a tabin bed to alert staff to attempts. The care plan the alarm should be puring observation or was sleeping on her rebed was in a low posithe floor to the outside alarm was observed to near the outside of the wall as indicated of the string attached to During interview on 1 assistant (NA)-A state the outside of the bed not aware that the moplaced on the bed near the care plan is updat print out a new Karde aids to follow. NA-A of the care plan is updat print out a new Karde aids to follow. NA-A of the care plan is updat print out a new Karde aids to follow. NA-A of the care plan is updat print out a new Karde aids to follow. NA-A of the care plan is updat print out a new Karde aids to follow. NA-A of the care plan is updat print out a new Karde aids to follow. NA-A of the care plan is updat print out a new Karde aids to follow. NA-A of the care plan is updat print out a new Karde aids to follow. NA-A of the care plan is updat print out a new Karde aids to follow. NA-A of the care plan is updat print out a new Karde aids to follow. NA-A of the care plan is updat print out a new Karde aids to follow. NA-A of the care plan is updat print out a new Karde aids to follow. NA-A of the care plan is updat print out a new Karde aids to follow. NA-A of the care plan is updat print out a new Karde aids to follow. NA-A of the care plan is updat print out a new Karde aids to follow.	Intering) medications. The for R53 to avoid nimize the risk of falling. In w dated 10/21/16, indicated and on 10/19/16, the review nitoring alarm did not tempted to get out of bed as to the outside of the bed. The care plan was revised to coring device was placed on wall, so that the alarm would fir that R53 was up and If 10/29/16, directed staff as alarm (monitoring alarm) R53's self transfer and id not indicate where placed on R53's bed. In 11/10/16, at 9:09 a.m. R53 right side facing the wall, the tion and a fall matt was on the of the bed. A monitoring to be attached to the bed are bed, rather than closer to on the Post Fall Review, with	2 830			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			TE SURVEY MPLETED	
		00109	B. WING		1.	1/10/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
COMMUN	IITY MEMORIAL HOME		T MAIN STREET				
	CLIMMADY CT	ATEMENT OF DEFICIENCIES	MN 56360	DDOVIDEDIO DI ANI OF	CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 830	Continued From page	e 10	2 830				
	not direct the staff wh alarm.	ere to place the monitoring					
	medication assistant monitoring alarm was the bed near the wall to get out of bed the a review of the Kardex stated that it would be to reflect where to plate to review any new interval propriate are then appropriate are then appropriate are then assistants to follow. If all on 10/18/16, R53 and that during the fastated the intervention monitoring alarm on the further stated that the to reflect the placement.)-A that following the post fall ventions assessed to be added to the care plan. nat a Kardex that is linked to printed for the nursing RN-A stated that prior to the did have a monitoring alarm II it did not sound. RN-A					
	alarm should have be that the care plan sho reflect the location the	ON) stated the monitoring een placed near the wall and buld have been updated to e monitoring alarm should emportant to attempt to com bed.					
	revised 12/14, directed fall assessment and in possible, and prevent	Incident/Accident policy ed staff to complete a post dentify a root cause, if toture recurrences of a nt. The policy also directed					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		00109	B. WING		11	/10/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE		
COMMUN	ITY MEMORIAL HOME		ST MAIN STREET , MN 56360			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
2 830	staff to determine chaindicated. SUGGESTED METH The director of nursin develop policies and assessing and monitor interventions are in pleased as the could educate staff or procedures. The DO develop a monitoring receive the appropria	OD FOR CORRECTION: g (DON) or designee could procedures regarding oring accidents to ensure ace. The DON or designee in the policies and N or designee could system to ensure residents	2 830			

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