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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: I7WW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00681

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

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

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

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/02/2012** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

A Post Certification Revisit (PCR) was completed by the Department of Health to verify correction of deficiencies issued pursuant to the February 16, 2012. Based on the PCR, it has been determined that the facility has achieved substantial compliance pursuant to the February 16, 2012 standard survey, effective April 2, 2012. Refer to the CMS 2567b for health.

Effective April 2, 2012, the facility is certified for 45 skilled nursing facility beds.

17. SURVEYOR SIGNATURE — Date :
Maria King, Unit Supervisor — 04/05/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Program Specialist — 05/15/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
03/27/2012 (L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5440

May 15, 2012

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

Dear Mr. Madel III:

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

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

Effective April 2, 2012 the above facility is certified for:

45 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 5, 2012

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

RE: Project Number S5440022

Dear Mr. Madel III:

On February 28, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 16, 2012. 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 April 2, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 16, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 2, 2012. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 16, 2012, effective April 2, 2012 and therefore remedies outlined in our letter to you dated February 28, 2012, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

Maria King

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

Enclosure

cc: Licensing and Certification File 5440r12.rtf

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245440	A. Building B. Wing	4/2/2012

Name of Facility	Street Address, City, State, Zip Code
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0205** Reg. # **483.12(b)(1)&(2)** LSC	Correction Completed **04/02/2012**	ID Prefix **F0221** Reg. # **483.13(a)** LSC	Correction Completed **04/02/2012**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **04/02/2012**
ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **04/02/2012**	ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **04/02/2012**	ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **04/02/2012**
ID Prefix **F0276** Reg. # **483.20(c)** LSC	Correction Completed **04/02/2012**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **04/02/2012**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **04/02/2012**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **04/02/2012**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **04/02/2012**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **04/02/2012**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **04/02/2012**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **04/02/2012**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **04/02/2012**

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/MK	04/05/2012	08769	047/02/2012
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 2/16/2012

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: I7WW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00681

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245440**
2.STATE VENDOR OR MEDICAID NO.
(L2) **765240200**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/16/2012** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
At the time of the February 16, 2012 standard survey the facility was not in substantial compliance with Federal participation requirements. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE Date :
Connie Brady, HFE NEII 03/20/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 03/22/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 3/27/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 6056

February 28, 2012

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

RE: Project Number S5440022

Dear Mr. Madel III:

On February 16, 2012, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Maria King
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001

Telephone: (507) 344-2716

Fax: (507) 344-2723

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 27, 2012, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 27, 2012 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 16, 2012 (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 August 16, 2012 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File S5440022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING _____ B. WING _____	02/16/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 205 SS=D	483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section. This REQUIREMENT is not met as evidenced by:	F 205	Plan accepted mtg/gw 3/20/12 RECEIVED MAR 13 2012 Minnesota Dept of Health Mankato	

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

RPMalee III | Administrator | 3-10-2012

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING _____ B. WING _____	02/16/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 205	Continued From page 1 Based on interview and document review, the facility failed to provide the resident or legal representative written notification of the facility's bed-hold policy at the time the resident was transferred to the hospital for 1 of 1 resident (R30) in the sample who required hospitalization. Findings include: R30 was hospitalized on 2/5/12 and did not receive a bed hold policy. The clinical record lacked documentation indicating that written notification regarding the bed hold policy was provided to the resident or legal representative at the time of the transfer. During an interview with R30's family member at 4:13 p.m. on 2/13/12, she stated she had not been notified of the facility's bed-hold policy when R30 was transferred and admitted to the hospital on 2/5/12. R30's medical record lacked any documentation that the resident or his family had been informed of the facility's bed hold policy at the time of transfer to the hospital on 2/5/12. During an interview with registered nurse-A at 3:38 p.m. on 2/15/12, she verified R30's medical record lacked any documentation that bed-hold information had been given to the resident or his family when he was transferred to the hospital. During an interview with the director of nursing at 4:10 p.m. on 2/15/12, she was unable to find any information that indicated the resident or his family had been informed of the facility's bed-hold policy.	F 205	We disagree with the surveyors findings in this area. We feel their findings are anecdotal in nature and in no way rise the the level of a deficiency. The plan of correction that follows is written solely to maintain certification in the Medicare and Medical Assistance programs. These written responses do not constitute an admission of noncompliance with any finding. We wish to preserve our right to dispute these findings in their entirety at any time and in any legal action. We may submit a separate request for Informal Dispute Resolution for certain findings and determinations. In the spirit of cooperation we have taken the following steps: It should be noted that during this period of time, that our census was below the minimum level to allow us to bill for bed holds. It should also be noted that this was a one time occurance and that in the last year we had not been able to bill for bed holds. The organizations policy on notifying families of the bed hold policy was reviewed with the business office, nursing administration, and the social worker to ensure that everyone is aware of the regulation and the policy. Checks and balances were put into place to ensure that all residents are made aware of their right to hold a bed. RECEIVED MAR 13 2012 Minnesota Dept of Health Mankato	4-2-12

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F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to use the least restrictive device for the least amount of time for 1 of 3 residents (R24) in the sample who utilized a lap belt in his wheelchair that prevented him from transferring from the wheelchair independently. Findings include: R24 was observed restrained with a lap belt that was not used the least amount of time possible. During initial observations at 1:45 p.m. on 2/13/12, R24 was observed seated in his wheelchair in his room with a lap belt across his lap. The belt had a push button release on it. During observation of cares on 2/14/12 at 12:30 p.m., R24 was observed seated in the dining room at the table in his wheelchair with a lap belt across his lap. During the observation Registered Nurse (RN)-B sat directly beside R24 and assisted him to eat. R24 continued to have his lap belt across his lap. At 12:58 p.m. on 2/14/12, R24's wife was interviewed about the lap belt. She stated R24	F 221	We disagree with the surveyors findings in this area. We feel their findings are anecdotal in nature and in no way rise the the level of a deficiency. The plan of correction that follows is written solely to maintain certification in the Medicare and Medical Assistance programs. These written responses do not constitute an admission of noncompliance with any finding. We wish to preserve our right to dispute these findings in their entirety at any time and in any legal action. We may submit a separate request for Informal Dispute Resolution for certain findings and determinations. In the spirit of cooperation we have taken and will take the following steps. The resident in question has been re-assessed and the care plan was adjusted to reflect the new assessment. New admissions will be assessed by PT and OT as ordered. During initial assessment when mobility and functionality are being assessed, input will be obtained to assure that residents are in an appropriate w/c with appropriate positioning aids to promote optimum independent mobility and safety. Restraint assessments will be reviewed quarterly with the care conference on the MDS quarterly review sheet. Family or resident Consent and MD orders will be obtained and care planned. Nursing will complete a restraint assessment annually. The MDS Coordinator and Director of Nuring will monitor this area to ensure continued compliance. Spot audits will be performed and the results will be reported to the Quality Improvement committee at its quarterly meeting.	4-2-12

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F 221	Continued From page 3 was unable to remove the belt independently. She stated, "Thank God he cannot remove it or he would try to get up and fall. That keeps him from being able to get up without help. He used to fall a lot until I was moved into his room with him. Now I can keep an eye on him." She verified R24 was able to attempt to transfer independently and verified the belt restricted his ability to exit the wheelchair. During observation of morning cares at 6:45 a.m. on 2/15/12, R24 was observed seated in his wheelchair in his room with a seat belt across his lap. He was also noted to have a chair alarm attached to his shirt sleeve. At 8:20 a.m. R24 was observed seated at the dining room table in his wheelchair with the lap belt across his lap. During the observation he was being assisted with eating with nursing assistant (NA)-A sitting directly beside him. At 10:30 a.m. on 2/15/12 RN-A was interviewed and stated R24's wife requested he have the belt on when up in his chair. She stated she was not sure how appropriate it is now because she was unsure if he could still transfer independently. RN-A stated R24 would probably be able to self transfer but it would not be safe. She also stated she had never observed him to be able to independently remove the belt. R24's Physical Restraint Assessment dated 10/21/11, identified he had 2 1/2 side rails to assist with repositioning. The assessment also identified he had, "Physical alarms, tray table or lap buddy -more restrictive." Use for the devices was identified as "necessary due to a history of falls, confusion, and cognitive deficit related to	F 221		

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F 221	Continued From page 4 dementia." The assessment further identified when R24 used alarms he continued to fall thus the seat belt was " least restrictive (lap buddy or tray table)." R24's Care Plan for Fall Risk dated 12/15/11, identified him at risk for injury related to falls. Interventions were identified as follows: Call light within reach, assist with ambulation, 1/2 rails on bed to aid in bed mobility and repositioning, personal alarm, floor alarm and floor mat, scoop mattress in bed, Wanderguard, personal wheelchair with seat belt. Use seat belt when up in chair per family request. EZ stand lift for transfers. During an interview with the director of nursing (DON) at 10:00 a.m. on 2/16/12, she stated R24 wore the seatbelt to prevent him from attempting to transfer independently. She stated if he attempted to transfer without it he would likely fall. When asked if he needed to utilize the restraint when he was in direct observation by staff, the DON stated she had never made the recommendation for staff to remove the restraint when they were directly supervising the resident. The facility failed to utilize R24's restraint in a manner where it was the least restrictive device for the least amount of time. The facility had no plan to remove the device at times when the resident was in direct observation of staff to include meal and activity times. The resident was identified to use the device to prevent unsafe independent transfers.	F 221		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225		

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F 225	Continued From page 5 The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 225	We disagree with the surveyors findings in this area. We feel their findings are anecdotal in nature and in no way rise the the level of a deficiency. The plan of correction that follows is written solely to maintain certification in the Medicare and Medical Assistance programs. These written responses do not constitute an admission of noncompliance with any finding. We wish to preserve our right to dispute these findings in their entirety at any time and in any legal action. We may submit a separate request for Informal Dispute Resolution for certain findings and determinations. In the interest of cooperation we have taken the following steps: Our Vulnerable Adult Polcy, which deals with reporting and investigating vulnerable adult issues, has been reviewed and revised. In particular, the guidelines for what to report and what incidents trigger a full investigation have been clarified. The revisions will be discussed at the nursing staff meeting on March 14th to educate all staff members and help clarify what is reportable and needs investigation. This will ensure that all staff are on guard and working together to ensure that all reportable incidents are handled appropriately. The Director of Nursing will monitor this area to ensure continued compliance. Spot audits will be performed and the results reported back to the Quality Improvement committee at its quarterly meeting.	4-2-12

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F 225	Continued From page 6 by: Based on observation, interview and document review, the facility failed to investigate and report injuries of unknown origin in accordance with the 'Facility Prevention of Maltreatment Policy and Procedure' for 1 of 1 resident (R40) in the sample who sustained injuries of unknown origin. Findings include: The facility failed to complete an investigation into a bruise of unknown origin for R40 and failed to report the injury to officials in accordance with State law. R40's medical record was reviewed. The Nurse Progress Notes dated 11/27/11, indicated the resident had a "5 inch by 3 inch red to purple bruise on his right upper back. [R40] denies pain, no swelling or drainage, and he doesn't remember doing anything to it but said he could have bumped it getting in and out of the car when he went out with family 2 days ago." The note also identified R40 as having "several bruises on his front side also." R40's care plan dated 8/25/11, identified he needed extensive assistance of 2 staff with transfers and sometimes required the use of an EZ stand (mechanical lift device) to transfer. The facility maintained a log that tracked incidents. An entry for 11/27/11, at 7:30 p.m. identified R40 with a bright purple, red bruise on his right back shoulder that measured 5 x 3 inches. The cause of the injury was documented as unknown and staff documented he could have bumped it when out of the building.	F 225		

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F 225	Continued From page 7 R40's quarterly Minimum Data Set (MDS) assessment dated 10/5/11, identified him with a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. However, R40's nurses' notes identified he had been experiencing episodes of lethargy and confusion and was unable to respond appropriately to questions at times. The MDS identified R40 as requiring extensive assistance of 2 staff with transfers, dressing, toileting and identified he was unable to ambulate. During interview with the director of nursing (DON) at 2:10 p.m. on 2/16/12, she verified the injury was of unknown origin. The DON confirmed she had not investigated the injury to rule out abuse and verified there had been no report made to outside agencies related to the injury. The Facility's Prevention of Maltreatment Policy and Procedure dated 1/2011, identified all allegations of suspected maltreatment would be immediately reported to the administrator who would immediatley notify the DON. There was no documentation to indicate that the administrator or DON had received a report related to R40's bruising of unknown origin from 11/27/11. The facility's policy also indicated when reporting to outside agencies the facility DON, administrator, or social worker would immediately make a telephone report to the Vulnerable Adult Worker for Waseca County. The policy then identified, for incidents that are reportable by State guidelines, the Common Entry Point (CEP) must be notified within 24 hours of the discovery	F 225		

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F225	Continued From page 8 of the incident. For incidents reportable to meet federal guidelines, the facility will send an initial report to the Minnesota Department of Health within 24 hours of discovery of the incident. However, no report of the injury of unknown origin for R40 had been made to officials in accordance with State law. For injuries of unknown origin the DON stated the facility utilized the Care Providers of Minnesota guidance; Version 1.3, dated 8/8/08. This guidance included, "An injury should be classified as an injury of unknown source when both of the following conditions are met: 1. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident. 2. The injury was suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time or the incidence of injuries over time." The facility failed to report and investigate an injury of unknown origin for R40. The notes identified R40 required extensive assistance of staff to transfer and ambulate. The incident documentation conclusion was that the cause of the injury on R40's back was potentially caused by bumping it when getting out of a car. However, there was no investigation to identify if services were being provided as directed by the care plan, or if the injury occurred by some other means. Although the resident was able, at times, to communicate his needs, he also experienced episodes of confusion and was unable to recall past events. There was no documentation that the family had been interviewed regarding the	F 225		

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F 225	Continued From page 9 resident's outing. There was no documentation provided by the facility to identify a thorough investigation had been conducted to rule out abuse. The facility also failed to report the injury of unknown origin immediately.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to operationalize policies to ensure prompt reporting and investigation of injuries of unknown origin for 1 of 1 residents (R40) in the sample who sustained an injury of unknown origin. Findings include: The facility failed to thoroughly investigate injuries of unknown origin for R40 and failed to report the injury to the administrator and officials in accordance with State law per their policy. R40's medical record was reviewed. The Nurse Progress Notes dated 11/27/11, indicated the resident had a "5 inch by 3 inch red to purple bruise on his right upper back. [R40] denies pain, no swelling or drainage, and he doesn't remember doing anything to it but said he could have bumped it getting in and out of the car when he went out with family 2 days ago." The note	F 226		

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F 226	Continued From page 10 also identified R40 as having "several bruises on his front side also." R40's care plan dated 8/25/11, identified he needed extensive assistance of 2 staff with transfers and sometimes required the use of an EZ stand (mechanical lift device) to transfer. The facility maintained a log that tracked incidents. An entry for 11/27/11, at 7:30 p.m. identified R40 with a bright purple, red bruise on his right back shoulder that measured 5 x 3 inches. The cause of the injury was documented as unknown and staff documented he could have bumped it when out of the building. R40's quarterly Minimum Data Set (MDS) assessment dated 10/5/11, identified him with a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. However, R40's nurses' notes identified he had been experiencing episodes of lethargy and confusion and was unable to respond appropriately to questions at times. The MDS identified R40 as requiring extensive assistance of 2 staff with transfers, dressing, toileting and identified he was unable to ambulate. The Facility's Prevention of Maltreatment Policy and Procedure dated 1/2011, identified all allegations of suspected maltreatment would be "immediately" reported to the administrator who would immediately notify the DON. There was no documentation to ensure this had occurred. In addition the policy indicated an investigation would be initiated, "The DON, administrator or social worker will contact the necessary individuals (staff, residents, family members,	F 226	We disagree with the surveyors findings in this area. We feel their findings are anecdotal in nature and in no way rise the the level of a deficiency. The plan of correction that follows is written solely to maintain certification in the Medicare and Medical Assistance programs. These written responses do not constitute an admission of noncompliance with any finding. We wish to preserve our right to dispute these findings in their entirety at any time and in any legal action. We may submit a separate request for Informal Dispute Resolution for certain findings and determinations. In the interest of cooperation we have taken the following steps: Our Vulnerable Adult Polcy, which deals with reporting and investigating vulnerable adult issues, has been reviewed and revised. In particular, the guidelines for what to report and what incidents trigger a full investigation have been clarified. The revisions will be discussed at the nursing staff meeting on March 14th to educate all staff members and help clarify what is reportable and needs investigation. This will ensure that all staff are on guard and working together to ensure that all reportable incidents are handled appropriately. The Director of Nursing will monitor this area to ensure continued compliance. Spot audits will be performed and the results reported back to the Quality Improvement committee at its quarterly meeting.	4-2-12

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F 226	Continued From page 11	F 226		

roommate) to ascertain the facts of the report are correct and to add further details. This information will be documented on the incident report." A thorough investigation had not been conducted. The policy also indicated when reporting to outside agencies the facility DON, administrator, or social worker would immediately make a telephone report to the Vulnerable Adult Worker for the County. The policy then identified, for incidents that are reportable by State guidelines, the Common Entry Point (CEP) must be notified within 24 hours of the discovery of the incident. For incidents reportable to meet federal guidelines, the facility will send an initial report to the Minnesota Department of Health within 24 hours of discovery of the incident. However, no report of the injury of unknown origin for R40 had been made to officials in accordance with State law.

The facility failed to report and investigate an injury of unknown origin for R40. The notes identified R40 required extensive assistance of staff to transfer and ambulate. The incident documentation conclusion was that the cause of the injury on R40's back was potentially caused by bumping it when getting out of a car. However, there was no investigation to identify if services were being provided as directed by the care plan, or if the injury occurred by some other means. Although the resident was able, at times, to communicate his needs, he also experienced episodes of confusion and was unable to recall past events. There was no documentation that the family had been interviewed regarding the resident's outing. There was no documentation provided by the facility to identify a thorough investigation had been conducted to rule out

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F 226	Continued From page 12 abuse. The facility also failed to report the injury of unknown origin immediately.	F 226		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide accommodations for adequate wheelchair positioning for 2 of 3 residents (R24 and R15) in the sample reviewed for positioning needs. Findings include: The facility failed to provide adequate wheelchair positioning and foot rests for R24. During observation of resident cares at 8:13 a.m. on 2/14/12, R24 was observed to be wheeled into the dining room from his room by his wife. During the observation R24's feet were noted to be dragging along the floor while being wheeled. The dragging of his feet was audible from approximately 20 feet away. At 8:45 a.m. on 2/14/12, R24 was wheeled back to his room and he was noted to have his feet dragging on the floor. During observation of R24 in his wheelchair in his room at 9:00 a.m. on 2/15/12, he was noted	F 246		

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F 246	Continued From page 13 to be sitting in his wheelchair with his pelvis forward and his knees bent upward. His wheelchair was observed to be too short for him and he was mal-positioned while seated. During observation of cares on 2/15/12, at 8:00 a.m. and again at 11:58 a.m., R24 was observed to have been wheeled from his room to the dining room, and back, with his feet dragging on the floor each time. At 10:20 a.m. on 2/15/12, the facility's physical therapist (PT) was asked to look at R24's positioning with the surveyor. The PT entered R24's room and looked at his wheelchair positioning and stated R24 was not positioned well. The PT stated upon initial observation it appeared R24 would benefit from a wheelchair that was higher, and further stated R24 should have foot rests on his chair to keep his feet from going back under the chair when staff were assisting him to destinations. She stated R24 might benefit from a different cushion to keep his buttocks back in chair. The PT verified staff had not made a recommendation for an evaluation of R24's wheelchair positioning and verified his positioning could be improved. During interview with registered nurse (RN)-A on 2/15/12 at 2:00 p.m., she stated there had not been any referrals made for wheelchair positioning for R24 and stated the family had brought the chair in for the resident and wanted him to use it. RN-A also stated there had been no discussion with the family related to his positioning in his wheelchair. R24 failed to have his wheelchair positioning	F 246	We disagree with the surveyors findings in this area. We feel their findings are anecdotal in nature and in no way rise the the level of a deficiency. The plan of correction that follows is written solely to maintain certification in the Medicare and Medical Assistance programs. These written responses do not constitute an admission of noncompliance with any finding. We wish to preserve our right to dispute these findings in their entirety at any time and in any legal action. We may submit a separate request for Informal Dispute Resolution for certain findings and determinations. In the spirit of cooperation we have taken the following steps.: New admissions will be assessed by physical therapy and occupational therapy as ordered. During initial assessment, when mobility and functionality are being assessed, input from family and staff will be obtained to assure that residents are in an appropriate w/c with appropriate positioning aids to promote optimum independent mobility. A premium will be place on maintaining resident independence and dignity. The therapy department will screen residents quarterly with MDS assessments to ensure that residents are in appropriate wheelchairs with proper positioning. The MDS Coordinator and the Director of Nursing will monitor this area to ensure continued compliance. Results will be reported to the Quality Improvment Committee at its quarterly meeting.	4-2-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING _____ B. WING _____	02/16/2012

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F 246	Continued From page 14 needs assessed to accommodate good wheelchair positioning and safety while being wheeled in his wheelchair. The facility failed to provide adequate wheelchair positioning for R15. During observation of resident cares at 11:33 a.m. on 2/14/12, R15 was observed to be wheeled down the hallway from his room to the dining room by a dietary assistant. His feet were observed dragging on the floor and could be heard scraping against the floor. R15 was noted to be wearing black dress shoes and his wheelchair lacked any foot rests to support his feet while being wheeled in his wheelchair. During observation of R15 on 2/15/12 and 2/16/12 a NA wheeled the resident to the breakfast and noon meals. The resident's feet were noted to be slightly back under the wheelchair and his feet could be heard dragging across the floor during these times of transport. On all observations, there were no foot rests on R15's wheelchair. During an interview with RN-A at 12:15 p.m. on 2/16/12, she stated R15 had been in his current chair for approximately 3 months. She stated nursing was responsible to assess wheelchair needs and stated the facility recently had contracted a new therapy service which could be utilized to assess wheelchair positioning. RN-A verified R15 did not propel himself in his wheelchair and stated he should have foot rests on his chair when being wheeled. She verified there had not been an assessment of his wheelchair positioning or referrals made to	F 246		

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F 246	Continued From page 15 therapy. The facility failed to reassess and provide adequate mobility and positioning for R15 while being wheeled in his wheelchair.	F 246		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and	F 272		

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F 272	Continued From page 16 Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess 1 of 3 residents (R24) in the sample for wheelchair positioning needs. Findings include: The facility failed to complete a comprehensive assessment of R24's wheelchair positioning needs during his annual review. During observation of resident cares at 8:13 a.m. on 2/14/12, R24 was observed to be wheeled into the dining room from his room by his wife. During the observation R24's feet were noted to be dragging along the floor while being wheeled. The dragging of his feet was audible from approximately 20 feet away. At 8:45 a.m. on 2/14/12, R24 was wheeled back to his room and he was noted to have his feet dragging on the floor. During observation of R24 in his wheelchair in his room at 9:00 a.m. on 2/15/12, he was noted to be sitting in his wheelchair with his pelvis forward and his knees bent upward. His wheelchair was observed to be too short for him and he was mal-positioned while seated. During observation of cares on 2/15/12, at 8:00	F 272	We disagree with the surveyors findings in this area. We feel their findings are anecdotal in nature and in no way rise the the level of a deficiency. The plan of correction that follows is written solely to maintain certification in the Medicare and Medical Assistance programs. These written responses do not constitute an admission of noncompliance with any finding. We wish to preserve our right to dispute these findings in their entirety at any time and in any legal action. We may submit a separate request for Informal Dispute Resolution for certain findings and determinations. In the spirit of cooperation we have taken the following steps: New admissions will be assessed by physical therapy and occupational therapy as ordered. During initial assessment, when mobility and functionality are being assessed, input from family and staff will be obtained to assure that residents are in an appropriate w/c with appropriate positioning aids to promote optimum independent mobility. A premium will be place on maintaining resident independence and dignity. The therapy department will screen residents quarterly with MDS assessments to ensure that residents are in appropriate wheelchairs with proper positioning. The MDS Coordinator and the Director of Nursing will monitor this area to ensure continued compliance. Results will be reported to the Quality Improvment Committee at its quarterly meeting.	4-2-12

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F 272	Continued From page 17 a.m. and again at 11:58 a.m., R24 was wheeled from his room to the dining room and back with his feet dragging on the floor each time. R24's annual Minimum Data Set (MDS) assessment, dated 12/2/11, identified he needed extensive assistance of 1 staff with transfers, and as being unable to ambulate. At 10:20 a.m. on 2/15/12, the facility physical therapist (PT) was asked to look at R24's positioning with the surveyor. The PT entered R24's room and looked at his wheelchair positioning and stated R24 was not seated well. She stated upon initial observation it appeared R24 would benefit from a wheelchair that was higher. She further stated R24 should have foot rests on his chair to keep his feet from going back under chair when staff were assisting him to destinations. She stated R24 might benefit from a different cushion to keep his buttocks back in chair. The PT verified staff had not made a recommendation for an evaluation of R24's wheelchair positioning and verified his positioning could be improved. During interview with registered nurse (RN)-A on 2/15/12, at 2:00 p.m. she stated there had not been any referrals made for wheelchair positioning for R24 and stated the family had brought the chair for the resident and wanted him to use it. RN-A stated there had been no discussion with the family related to R24's positioning in his wheelchair. R24 failed to have his wheelchair positioning needs assessed to accommodate good wheelchair positioning and safety while being	F 272		

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F 272	Continued From page 18 wheeled in his wheelchair.	F 272	We disagree with the surveyors findings in this area. We feel their findings are anecdotal in nature and in no way rise the the level of a deficiency. The plan of correction that follows is written solely to maintain certification in the Medicare and Medical Assistance programs. These written responses do not constitute an admission of noncompliance with any finding. We wish to preserve our right to dispute these findings in their entirety at any time and in any legal action. We may submit a separate request for Informal Dispute Resolution for certain findings and determinations. In the spirit of cooperation we have taken the following steps: New admissions will be assessed by physical therapy and occupational therapy as ordered. During initial assessment, when mobility and functionality are being assessed, input from family and staff will be obtained to assure that residents are in an appropriate w/c with appropriate positioning aids to promote optimum independent mobility. A premium will be place on maintaining resident independence and dignity. The therapy department will screen residents quarterly with MDS assessments to ensure that residents are in appropriate wheelchairs with proper positioning. The MDS Coordinator and the Director of Nursing will monitor this area to ensure continued compliance. Results will be reported to the Quality Improvment Committee at its quarterly meeting.	4-3-12
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to reassess 1 of 3 residents (R15) in the sample who had inadequate foot support when seated in his wheelchair. Findings include: The facility failed to complete a reassessment for wheelchair positioning for R15 during his quarterly review. During observation of resident cares at 11:33 a.m. on 2/14/12, R15 was observed to be wheeled down the hallway from his room to the dining room by a dietary assistant. His feet were observed dragging on the floor and could be heard scraping against the floor. R15 was noted to be wearing black dress shoes and his wheelchair lacked any foot rests to support his feet while being wheeled in his wheelchair. During observation of R15 on 2/15/12 and 2/16/12 a nursing assistant wheeled the resident to the breakfast and noon meals. The resident's feet were noted to be slightly back under the	F 276		

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F 276	Continued From page 19 wheelchair and his feet could be heard dragging across the floor during these times of transport. On all observations, there were no foot rests on R15's wheelchair. R15's quarterly Minimum Data Set (MDS) assessment dated 12/30/11, identified the resident as dependent on staff for mobility and needing extensive assistance of 1 to 2 staff with transfers and ambulation. During an interview with registered nurse (RN)-A at 12:15 p.m. on 2/16/12, she stated R15 had been in his current chair for approximately 3 months. She stated nursing was responsible to assess wheelchair needs and stated the facility recently had contracted a new therapy service which could be utilized to assess wheelchair positioning. RN-A verified R15 did not propel himself in his wheelchair and stated he should have foot rests on his chair when being wheeled. She verified there had not been an assessment of his wheelchair positioning or referrals made to therapy. The facility failed to reassess R15's mobility and positioning needs while being wheeled in his wheelchair.	F 276		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's	F 279		

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F 279	Continued From page 20 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop a comprehensive care plan for 1 of 3 residents (R40) to meet the resident's medical and nursing needs. Findings include: R40's plan of care did not identify the potential for repeated bruising. R 40 was admitted to the facility on 8/8/11 with diagnoses that included: anemia and thrombocytopenia. Review of the nursing notes for R40 identified repeated incidents of bruising and sometimes the bruising was extensive in nature and involved multiple areas of his body. The plan of care identified only the risk for skin breakdown, but failed to include the potential for	F 279	We disagree with the surveyors findings in this area. We feel their findings are anecdotal in nature and in no way rise the the level of a deficiency. The plan of correction that follows is written solely to maintain certification in the Medicare and Medical Assistance programs. These written responses do not constitute an admission of noncompliance with any finding. We wish to preserve our right to dispute these findings in their entirety at any time and in any legal action. We may submit a separate request for Informal Dispute Resolution for certain findings and determinations. In the spirit of cooperation we have taken the following steps: Bruising has been added to R40's care plan. While not spelled out specifically, in our practice brusing is part of skin breakdown. Nurses chart weekly on skin condition and any changes are to be reflected in the care plan. A nursing department meeting will be held on March 14th. At that time weekly nursing charting on skin conditions will be reviewed. Nurses will be instructed that skin breakdown covers many areas and that brusing should be charted and care planned for. Organization policies will be reviewed and clarified. The Director of Nursing will monitor this area to ensure continued compliance. Spot audits will be performed to ensure continued compliance. Results will be reported to the Quality Improvement committee at its quarterly meeting.	4-2-12

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F 279	Continued From page 21 bruising. The skin care approached included to monitor his skin daily with AM (morning) and PM (evening) care and with weekly w/p (whirlpool) bath. Notify charge nurse and MD (medical doctor) as appropriate for changes in skin condition. During interview at 11:15 a.m. on 2/16/12, with nursing assistant (NA)-C, verified that R40's skin is inspected daily in the morning but because the staff is so busy, NA-C verified that she really didn't notice anything abnormal related to R40's repeated bruising. During interview with registered nurse (RN)-B at 11:20 a.m.on 2/16/12, she was questioned whether R40's skin bruises frequently and easily, RN-B replied, "oh my, yes!" RN-B further added that if R40's skin is slightly red one day it will be black and blue the next day. During interview with the RN MDS (Minimum Data Set) Coordinator at 2:10 p.m.on 2/15/12, verified that the plan of care for R40 did not identify the potential for bruising related to the diagnosis of thrombocytopenia. Therefore no interventions had been developed to help prevent additional bruising.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed	F 280		

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F 280	Continued From page 22 within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to revise the plan of care to include non-pharmacological interventions related to the use of psychoactive medications for 1 of 3 residents (R30) residents reviewed in the sample. Findings include: R30 received Klonopin (anti-anxiety medication) 0.5 mg (milligrams) by mouth twice a day as needed for anxiety. The plan of care lacked any non-pharmacological interventions. R30 was admitted to the facility on 4/10/2009 and current diagnoses include: dementia with behavioral issues; depression and anxiety/agitation. R30's physician orders indicated the PRN Klonopin had been initiated on 1/31/12. The resident's plan of care indicated the resident utilized psychoactive medications, however no	F 280	We disagree with the surveyors findings in this area. We feel their findings are anecdotal in nature and in no way rise the the level of a deficiency. The plan of correction that follows is written solely to maintain certification in the Medicare and Medical Assistance programs. These written responses do not constitute an admission of noncompliance with any finding. We wish to preserve our right to dispute these findings in their entirety at any time and in any legal action. We may submit a separate request for Informal Dispute Resolution for certain findings and determinations. In the spirit of cooperation, we have taken the following steps: Currently, residents have target behavior sheets with interventions for staff to try to redirect residents behaviors. We have now adjusted the care plans to reflect the non-pharmacological interventions rather then refer to the "following interventions on the behavior sheet" At the Nursing Meeting on the 14th of March, staff will be educated on residents target behavior sheets. Non-pharmacological interventions will be reviewed along with their position on the care plans. Staff will be educated on adjusting target behavior sheets and the procedure for making them flow to the behavior section of the care plan. The MDS Coordinator and Director of Nursing will monitor this area to ensure continued compliance. Spot audits will be performed and the results reported at the quarterly Quality Improvement Committee meeting.	4-2-12

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F 280	Continued From page 23 non-pharmacological interventions had been developed for staff to utilize prior to using the PRN Klonopin. During interview with the registered nurse/MDS (Minimum Data Set) Coordinator at 10:30 a.m. on 2/15/12, she verified that the plan of care had not been revised to include any non-pharmacological interventions to be used prior to giving the PRN Klonopin.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide appropriate care and services for non-pressure related skin conditions for 1 of 3 residents (R8) in the sample who was reviewed for non pressure related skin issues. Findings include: The facility failed to assess and monitor for change, skin anomalies on the face and neck of R8. During observation of R8 at 4:52 p.m. on	F 309		

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F 309	Continued From page 24 2/13/12, she was noted to have multiple growths on the dermis of the left side of her face and neck. She was also noted to have growths on the dermis of her nose, forehead and right neck region. The areas were of differing sizes, dark, irregular edged, and protruded from the dermis. During an interview with registered nurse (RN)-B at 3:00 p.m. on 2/14/12, she stated the areas on R8's face and neck appeared to be large, irregular shaped moles or skin tags. RN-B stated there had been discussion with the resident and her physician about having the areas removed however, R8 had refused. RN-B stated she did not recall when the discussion occurred with the R8. R8's active care plan for skin, dated 2/2/12, identified she was at risk for skin breakdown. She was identified to have her skin monitored daily with a.m. (morning) and p.m. (evening) cares and weekly with her bath. Her care plan identified changes should be reported to the charge nurse as needed. The care plan addressed areas on her feet and pressure ulcer risk but did not identify the anomalies on her face and neck. During review of R8's medical record at 8:00 a.m. on 2/15/12, there was no documentation to indicate that assessment and ongoing monitoring were completed related to the anomalies of the skin for R8. At 9:51 a.m. on 2/15/12, RN-A was interviewed in reference to R8's skin condition. RN-A stated the nursing assistants (NA) reviewed resident skin during a.m. and p.m. cares and would let the nurses know if there was a concern. RN-A was	F 309	We disagree with the surveyors findings in this area. We feel their findings are anecdotal in nature and in no way rise the the level of a deficiency. The plan of correction that follows is written solely to maintain certification in the Medicare and Medical Assistance programs. These written responses do not constitute an admission of noncompliance with any finding. We wish to preserve our right to dispute these findings in their entirety at any time and in any legal action. We may submit a separate request for Informal Dispute Resolution for certain findings and determinations. In the spirit of cooperation we have taken the following steps: Skin assessments will be completed on admission and weekly X4. Residents skin will then monitored daily with cares and with weekly baths. Residents will have tissue tolerances completed per facility policy and any changes will be reported to the charge nurse. Treatments will be set up as necessary and physicians will be notified as needed. All nursing staff will be re-educated on facility policies and specific education will be given on the need to chart on all skin conditions, not just those that are pressure related. The Director of Nursing will monitor this area to ensure continued compliance. Results will be reported to the Quality Improvment Committee at its quarterly meeting.	4-2-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING _____ B. WING _____	02/16/2012

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

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F 309	Continued From page 25 asked if there was any monitoring conducted for R8's skin outside of pressure ulcer risk. She confirmed that no assessment to monitor the size or characteristics of the moles/skin tags was completed. The facility conducted a skin assessment on 1/23/12 that identified R8's skin as intact and identified her with venous stasis ulcers on legs. The assessment lacked any identification of the areas noted on R8's face and neck. When RN-A was asked how she would identify changes in skin condition if not comprehensively assessed to establish a baseline, she stated, "Good question." The facility failed to complete necessary assessment and monitoring for R8's skin to identify if there were significant changes in the areas of growth on her face and neck region. R8 had large, brown, and irregular shaped skin tags/moles that lacked ongoing monitoring to identify progression.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a resident's environment was as free of accident hazards as	F 323		

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F 323	Continued From page 26 possible for 1 of 3 residents (R40) reviewed who utilized side rails. Findings include: The facility failed to ensure R40's siderails were safe prior to use by the resident. R40 had been admitted to the facility on 8/8/11 with diagnoses including: Osteoarthrosis; asthma; acute gouty arthritis; rheumatoid arthritis; anemia and thrombocytopenia. During an observation of the resident's environment on 2/13/12 at 2:30 p.m., and again on 2/14/12 at 9:23 a.m., the resident's bed was noted to have half side rails in the up position on the outer sides of the bed. The rails were noted to be loose, moving easily side to side and front to back when physically touched. During observations of R40 at 6:35 a.m. on 2/15/12 during morning cares, the resident was observed to utilize the siderails to assist with mobility. The resident grasped the outer side rail with his right arm and pulled himself up putting pressure on the outer side rail. Review of the nursing notes revealed an incident had occurred for R40 on 12/29/11 at 4:15 am. According to the documentation, nursing staff had heard a strange sound about 4:15 a.m. and had found R40 in bed rolled onto his right side, legs out of bed, right arm down along his side on the bed, and his face and chest leaning into the siderail. Documentation indicated the resident's speech was thick and hard to understand. The resident had been incontinent of bowel. The	F 323	We disagree with the surveyors findings in this area. We feel their findings are anecdotal in nature and in no way rise the the level of a deficiency. The plan of correction that follows is written solely to maintain certification in the Medicare and Medical Assistance programs. These written responses do not constitute an admission of noncompliance with any finding. We wish to preserve our right to dispute these findings in their entirety at any time and in any legal action. We may submit a separate request for Informal Dispute Resolution for certain findings and determinations. In the spirit of cooperation we have taken the following steps: The policies for side rails have been reviewed. A new side rail assessment has been developed that addresses risks and benefits for each resident. All new admissions will be assessed using this new instrument. Side rail assessments have been completed on all current resident's and care plans have been reviewed to reflect changes. The Director of Nursing will monitor this area to ensure continued compliance. Spot audits will be completed to monitor ongoing compliance. Results will be reported to the Quality Improvment Committee at its quarterly meeting.	4-2-12

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F 323	Continued From page 27 documentation also indicated R40 had made no attempts to put his light on even though he normally did so when he needed something. At the time of the incident, R40 was observed to have had a bruise on his right shoulder that extended to his back and right scapular area extending down to his lower rib cage. A BIMS (Brief Interview of Mental Status) had been completed for R40 on 2/9/12, and identified the resident had scored 15/15 which indicated the resident had no problems with short or long term memory. During an interview with R40 at 4:50 p.m. on 2/14/12, he stated he did not remember the incident from 12/29/11. R40 stated he did not think he had gotten injured, and stated he did not remember having received any bruising as a result of the incident. R40 stated he had noticed that the side rails were very loose in the past, but stated that he had never really known what they were supposed to be like. The record included a Restraint Assessment for R40 dated 8/8/11 that indicated the resident utilized 2 half siderails when in bed to aid with bed mobility after a left hip replacement. No further assessment of the siderails, including safe use, had been conducted. The director of nurses (DON) was interviewed on 2/14/12 at 3:41 p.m. She stated she had been unaware of the incident from 12/29/11 when R40 had rolled into his side rail. She confirmed that although an incident report had been completed by LPN (licensed practical nurse)-C following the incident, the report had not been forwarded to her	F 323		

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F 323	Continued From page 28 for review. The DON verified no investigation into the incident had been conducted because she had not been aware of it. She confirmed there had been no additional assessment of the resident's siderails following the incident either. The DON stated that had she been informed of the incident, she probably would have come in and spoken to the resident to determine what had happened. She said LPN-C should have contacted her because that was the way their system routinely worked. When questioned about how they assessed siderails for safety, the DON stated their maintenance man measured all the siderails in the building. The DON confirmed no other mobility device, such as a grab bar, had been assessed for this resident's use. LPN-C was interviewed by telephone on 2/14/11 at 4:24 p.m., she confirmed the details of the incident as described above for R40. LPN-C stated that at the time of the 12/29/11 incident, R40 had rolled into, and basically was hugging, the side rail on his right side with his upper torso against the side rail with his legs out of the bed and his buttocks still on the bed. She said his left arm had been positioned between the bed and the siderail and his right arm was wrapped around the outer siderail. LPN-C stated that when R40 gets up "he normally leans against and grasps the siderail to to sit up. When we heard the noise coming from his room he was already in the process of getting up. He was putting a lot of pressure on the side rail as he routinely pushes and pulls when he gets up." LPN-C also stated she had filled out an incident report and then it was kept at the desk. She stated, "I didn't call the DON as he didn't hit his head."	F 323		

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F 323	Continued From page 29 During an additional interview with LPN-C at 6:30 a.m. on 2/15/12, she stated she had noticed that R 40's outer siderails were loose in the past but had never reported it to anybody. She stated she'd previously noticed that the outer side rail "flexed" when R40 attempted to sit up. The resident's side rails were observed to have been removed, and replaced by rails that did not move or flex on 2/14/12 at 4:30 p.m.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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F 329	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to adequately identify, assess, and monitor clinical indications for continued use of medications for 2 of 10 residents (R35 and R1) in the sample whose medications were reviewed. The Findings include: R35 received psychotropic medications and lacked clinical indications for use and monitoring of the medications effectiveness. R35's record was reviewed and revealed the resident had been admitted to the facility 3/7/11 with diagnoses that included Alzheimer's dementia and anxiety. A review of the nurses' notes and behavior monitoring flow sheets indicated the resident exhibited behaviors including: hitting, biting, kicking and swearing at staff. A quarterly MDS (minimum data set) assessment dated 9/9/11 revealed the resident was cognitively impaired and exhibited physical behaviors including hitting, kicking, and scratching on a daily basis. Verbal behaviors exhibited included screaming and swearing 4-6 days a week, but not daily. A quarterly MDS dated 12/9/11 also revealed the resident was cognitively impaired and exhibited physical and verbal behavioral symptoms. However the physical behaviors had occurred only 4-6 days a week, and the verbal behavioral symptoms had only occurred 1-3 days a week. A review of the resident's physician orders and medication administration records revealed the	F 329	We disagree with the surveyors findings in this area. We feel their findings are anecdotal in nature and in no way rise the the level of a deficiency. The plan of correction that follows is written solely to maintain certification in the Medicare and Medical Assistance programs. These written responses do not constitute an admission of noncompliance with any finding. We wish to preserve our right to dispute these findings in their entirety at any time and in any legal action. We may submit a separate request for Informal Dispute Resolution for certain findings and determinations. In the spirit of cooperation we have taken the following steps: Our consulting phamacist will review all residents'medications. In this case, the phamacist did identify the discrepancies, but the physician's did not elaborate on justification for medical necessity. In the future, referrals sent to Primary Care Providers will be reviewed, by the nursing department, for response to ensure the justifications are included. When the consulting pharmacist makes his quarterly visit, he will be given a copy of his previous recommendations. This will allow him to check and see if his recommendations have been followed. The Director of Nursing will monitor this area to ensure continued compliance. Spot audits will be performed to ensure continued compliance. Results will be reported to the Quality Improvement Committee at its quarterly metting.	4-2-12

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F 329	Continued From page 31 resident had utilized Seroquel 25 mg (milligrams) daily, and Risperdone 1.5 mg daily since admission. However, there had been no documented clinical indication or diagnoses for the use of these medications. On 3/15/11 a pharmacist's drug regimen review questioned the need for 2 antipsychotics and whether or not the Seroquel could be decreased to 12.5 mg in an effort to taper off the use of the medication. The physician's documented response included, "Yes (regarding the use of 2 antipsychotics), No tapering." A pharmacist's review from 4/19/11 indicated "2nd Notice" and included the same questions. The physician's documented response was dated 6/30/11 and included, "Seroquel decreased." On 10/18/11 the pharmacist's drug regimen review identified that Sinemet 25/100 mg three times per day had been initiated for Parkinsonism symptoms on 10/14/11. The pharmacist had documented that the symptoms may be due to the antipsychotic therapy, identifying the resident received both Risperdone and Seroquel, both of which are known to cause Parkinsonism with Risperdone having a higher overall incidence. The pharmacist had recommended discontinuation, dose reduction, or alternative antipsychotic agent be used if appropriate. The physician response was dated 2/16/12 which included, "continue meds." There was no further clinical justification documented regarding risks and/or benefits for continued use of the antipsychotic medications at current dosages. Registered nurse (RN)-A was interviewed at 1:15 p.m. on 2/15/12. She verified the resident's record failed to specifically indicate indications for	F 329		

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F 329	Continued From page 32 use or relevant diagnosis for the use of the Risperdone and Seroquel. In addition, RN-A stated no GDR had been attempted on the Risperdone, and the Seroquel dose had remained the same since 6/30/11. R1 received psychotropic medications and lacked clinical rational for continued use of the medication. R1 was admitted to the facility on 10/23/00 with diagnoses that included: mental retardation; depressive disorder and histrionic personality disorder. Review of R1's physician orders identified that Effexor XR (an antidepressant) 150 mg (milligrams) daily was initiated on 3/18/08. The consulting pharmacist's recommendation dated 3/15/11, identified the following notation: Please review the Effexor 150 mg for a dose reduction if appropriate. No reduction attempted upon last review of 9/10 due to history of failed dose reductions. If no reduction appropriate, please document the clinical rationale." The attending physician's documented response dated 4/19/11 included: "Continue same doses of Effexor XR and Resperidone." There was no documented clinical justification for continued use, or for the lack of dose reduction.	F 329		

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F 329	Continued From page 33 The director of nursing (DON) was interviewed at 11:30 a.m. on 2/16/11. The DON verified that no clinical rational could be found in the medical record related to the continued use, same dosage, or lack of dose reduction for the psychoactive medication.	F 329		
DE 371 CISS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to serve food under sanitary conditions which had the potential to affect all 39 residents residing in the facility. Findings include: Food was not served under sanitary conditions. During observation of the preparation and serving of breakfast on 2/16/12 at 7:25 a.m., Cook -A was observed to wear gloves while serving breakfast. Cook-A picked up the handle of a milk carton and poured a glass of milk. With the same gloved hands she took a cooked egg out of a	F 371		

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F 371	Continued From page 34 paper wrapper, touching the egg with her gloved hand. Cook-A then picked up the handle of the milk carton and poured another glass of milk. With the same gloved hands Cook-A took half a banana, pealed it with a knife and handled the half banana (without the skin) with her same gloved hands and placed it onto a plate. During interview at 7:40 a.m. on 2/16/12, Cook-A verified that the above practices constituted a break in infection control. During interview with the certified dietary manager at 7:45 a.m. on 2/16/12, she verified that all dietary staff had been educated on how to handle, prepare and serve foods using proper infection control practices. She confirmed the above scenario did not consitute proper infection control technique. During observations at 7:45 a.m. on 2/16/12, a sign was noted to be mounted above the hand washing sink in the kitchen with the following direction: "...Hands must be washed between any contamination .....that means touching anything that could be contaminated. Gloves may be placed on clean hands but gloves get contaminated the same as hands. Change Often. When contaminated, gloves must be removed, hands rewashed and gloves reapplied."	F 371	We disagree with the surveyors findings in this area. We feel their findings are anecdotal in nature and in no way rise the the level of a deficiency. The plan of correction that follows is written solely to maintain certification in the Medicare and Medical Assistance programs. These written responses do not constitute an admission of noncompliance with any finding. We wish to preserve our right to dispute these findings in their entirety at any time and in any legal action. We may submit a separate request for Informal Dispute Resolution for certain findings and determinations. In the spirit of cooperation we have taken the following steps: On March 1st, a meeting was held with all dietary staff and the regulation and facility policy on infection control practices in the kitchen were reviewed. Our policies and procedures were already in place, this was just a matter of one cook, who one time in a week made a slip-up. Staff was inserviced on proper infection control practices to make sure everyone is aware of the proper practices. The Dietary Manager will monitor this area to ensure continued compliance. Spot audits will be performed to ensure continued compliance. Results will be reported to the Quality Improvement Committee at its quarterly metting.	4-2-12
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to	F 428		

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F 428	Continued From page 35 the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: R1 received psychotropic medications and lacked clinical rational for continued use of the medication. In addition, there had been no attempts at dose reduction. R1 was admitted to the facility on 10/23/00 with diagnoses that included: mental retardation; depressive disorder and histrionic personality disorder. Review of R1's physician orders identified that Effexor XR (an antidepressant) 150 mg (milligrams) daily was initiated on 3/18/08. The consulting pharmacist's recommendation dated 3/15/11, identified the following notation: Please review the Effexor 150 mg for a dose reduction if appropriate. No reduction attempted upon last review of 9/10 due to history of failed dose reductions. If no reduction appropriate, please document the clinical rationale." The attending physician's documented response dated 4/19/11 included: "Continue same doses of Effexor XR and Resperidone." There was no documented clinical justification for continued use, or for the lack of dose reduction. However, the pharmacist had made no further recommendations related to this. The director of nursing (DON) was interviewed at 11:30 a.m. on 2/16/11. The DON verified that no	F 428	We disagree with the surveyors findings in this area. We feel their findings are anecdotal in nature and in no way rise the the level of a deficiency. The plan of correction that follows is written solely to maintain certification in the Medicare and Medical Assistance programs. These written responses do not constitute an admission of noncompliance with any finding. We wish to preserve our right to dispute these findings in their entirety at any time and in any legal action. We may submit a separate request for Informal Dispute Resolution for certain findings and determinations. In the spirit of cooperation we have taken the following steps Our consulting phamacist will review all residents'medications. In this case, the phamacist did identify the discrepancies, but the physician's did not elaborate on justification for medical necessity. In the future, referrals sent to Primary Care Providers will be reviewed, by the nursing department, for response to ensure the justifications are included. When the consulting pharmacist makes his quarterly visit, he will be given a copy of his previous recommendations. This will allow him to check and see if his recommendations have been followed. The Director of Nursing will monitor this area to ensure continued compliance. Spot audits will be performed to ensure continued compliance. Results will be reported to the Quality Improvement Committee at its quarterly metting.	4-2-12

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 36 clinical rational could be found in the medical record related to the continued use, same dosage, or lack of dose reduction for the psychoactive medication. Based on interview and document review, the facility failed to assure that drug regimen irregularities are reported to the attending physician and the director of nursing for 2 of 10 (R35 and R1) residents reviewed who received anti-psychotic medications without attempts of a gradual dose reduction or documented clinical rationale why a dose reduction would be contraindicated. The Findings include: R35 received psychotropic medications and lacked clinical indications for use and monitoring of the medications effectiveness. The pharmacist failed to identify these irregularities. R35's record was reviewed and revealed the resident had been admitted to the facility 3/7/11 with diagnoses that included Alzheimer's dementia and anxiety. A review of the nurses' notes and behavior monitoring flow sheets indicated the resident exhibited behaviors including: hitting, biting, kicking and swearing at staff. A quarterly MDS (minimum data set) assessment dated 9/9/11 revealed the resident was cognitively impaired and exhibited physical behaviors including hitting, kicking, and scratching on a daily basis. Verbal behaviors exhibited included screaming and swearing 4-6 days a week, but not daily. A quarterly MDS dated 12/9/11 also revealed the resident was cognitively impaired and exhibited physical and verbal behavioral symptoms. However the physical	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING _____ B. WING _____	02/16/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 37 behaviors had occurred only 4-6 days a week, and the verbal behavioral symptoms had only occurred 1-3 days a week. A review of the resident's physician orders and medication administration records revealed the resident had utilized Seroquel 25 mg (milligrams) daily, and Risperdone 1.5 mg daily since admission. However, there had been no documented clinical indication or diagnoses for the use of these medications. On 3/15/11 a pharmacist's drug regimen review questioned the need for 2 antipsychotics and whether or not the Seroquel could be decreased to 12.5 mg in an effort to taper off the use of the medication. The physician's documented response included, "Yes (regarding the use of 2 antipsychotics), No tapering." A pharmacist's review from 4/19/11 indicated "2nd Notice" and included the same questions. The physician's documented response was dated 6/30/11 and included, "Seroquel decreased." On 10/18/11 the pharmacist's drug regimen review identified that Sinemet 25/100 mg three times per day had been initiated for Parkinsonism symptoms on 10/14/11. The pharmacist had documented that the symptoms may be due to the antipsychotic therapy, identifying the resident received both Risperdone and Seroquel, both of which are known to cause Parkinsonism with Risperdone having a higher overall incidence. The pharmacist had recommended discontinuation, dose reduction, or alternative antipsychotic agent be used if appropriate. The physician response was dated 2/16/12 which included, "continue meds." There was no further clinical justification documented regarding risks and/or benefits for	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING _____ B. WING _____	02/16/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 38 continued use of the antipsychotic medications at current dosages. Registered nurse (RN)-A was interviewed at 1:15 p.m. on 2/15/12. She verified the resident's record failed to specifically indicate indications for use or relevant diagnosis for the use of the Risperdone and Seroquel. In addition, RN-A stated no GDR had been attempted on the Risperdone, and the Seroquel dose had remained the same since 6/30/11. The pharmacist verified at 11:24 a.m. on 2/16/12 that no relevant diagnosis or specific clinical indications had been documented by the physician for the use of the Risperdone and Seroquel. He confirmed he had never addressed this with the physician.	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING _____ B. WING _____	02/16/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 39 The facilility failed to ensure that the consulting pharacist identifed irregularites in the drug regimine for 1 of 10 R 35. the facility failed to do GDR's on R28 for the antidepressants trazodone and paxil and for the continued use of a statin drug admitted to facility 4/21/09 diagnoses include cva, diabetes mellitus, diabetes, depressive disorder, insomnia, htn, venous embo and thromb uns deep vessel lower extremity, htn, gout, kidney disease,insomnia, cardiovascular diesease, dementia, cataracts, hyperlipidemia, chem panel 11/14/2011 chem and bmp, lipid panel doen chol 124, trig 106 HDL 48 buspar increased 12/11/11 to 10 mg pm and stay at 5 mg pm paxil since 6/11/11 and buspar since 2/11/11 trazodone 9/29/11 last pharm note indicates paxil increase 6/11, buspar started 2/11 last reduction of trazodone was 7/10 please review for a reduction of b uspar or trazodone if appropriate per cms reg. ifa reduction is not in resident best interest please documetn the clinical rationale dated 9/15/11 md stated 10/13/11 "medications are medically necessary pharm review jan 12 and dec 11 1/19/12 response requested to drop statin to 10 mg hs due to lipid panel results and s/e of med poss. resident does have muscle pain and uses	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING _____ B. WING _____	02/16/2012

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

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F 428	Continued From page 40 aspercreme. physician responded "NOPE" paxil increased to 40 6/11/11	F 428	We disagree with the surveyors findings in this area. We feel their findings are anecdotal in nature and in no way rise the the level of a deficiency. The plan of correction that follows is written solely to maintain certification in the Medicare and Medical Assistance programs. These written responses do not constitute an admission of noncompliance with any finding. We wish to preserve our right to dispute these findings in their entirety at any time and in any legal action. We may submit a separate request for Informal Dispute Resolution for certain findings and determinations. In the spirit of cooperation we have taken the following steps: The facilities policy on and procedures on monitoring the temperature was reviewed and modified. Refrigerator temps will be monitored daily with clear postings of acceptable range of temperatures. Policies for medication storage will reviewed with staff at the meeting on March 14,2012. The need to maintain proper temperatures will be stressed. The Director of Nursing will monitor this area to ensure continued compliance. Spot audits will be completed to monitor ongoing compliance. Results will be reported to the Quality Improvment Committee at its quarterly meeting.	4-2-12
F 431 SS=C	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING _____ B. WING _____	02/16/2012

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

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F 431	Continued From page 41 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to store drugs and biologicals per manufacturer's storage recommendations in 1 of 1 medication rooms which had the potential to affect all 39 residents. Findings include: During inspection of the facility's medication storage room at 11:50 a.m. on 2/16/12, the refrigerator containing facility medications requiring refrigeration was observed. The refrigerator was noted to contain 1 vial of multi-dose Tuberculin purified protein derivative (PPD), 11 syringes of Hepatitis B vaccine, and 1 vial of multi-dose Influenza vaccine. The 3 items were located directly under the freezer compartment of the refrigerator and the boxes the items were stored in were noted to be wet and frozen. The solutions inside of the vials and syringes remained in liquid form but there was ice noted inside the containers and on the glass surfaces. The refrigerator thermometer recorded a temperature of 31 degrees Fahrenheit (F) when it was initially inspected. The manufacturer's literature indicated the Hepatitis vaccine was to be stored between 35-46 degrees F. It indictated the vaccine could lose potentancy when frozen. The manufacturer's literature indicated the Influenza vaccine be stored at 35-46 degrees F and should not be frozen.	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING _____ B. WING _____	02/16/2012

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JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

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F 431	Continued From page 42 The manufacturer's literature indicated the Tuberculin PPD should be stored at 35-46 degrees F and should not be frozen. During interview with the Consulting Pharmacist at 12:48 p.m. on 2/16/12, he verified the medications would no longer be appropriate for use as they were stored below the manufacturer's recommended temperature.	F 431		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/16/2012

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

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K 000	INITIAL COMMENTS Surveyor: 25822 FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Janesville Nursing Home was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. This facility will be surveyed as two separate buildings. The Janesville Nursing Home is a 1-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1965 and was determined to be of Type II(111) construction. In 1994, addition was constructed to the South Wing that was determined to be of Type II(111) construction. Because the original building and the 1 addition are of the same type of construction allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 45 beds and had a census of 39 at the time of the survey.	K 000		

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING 02 - 2008 LINK B. WING _____	02/16/2012

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

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K 000	INITIAL COMMENTS Surveyor: 25822 FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Janesville Nursing Home - Link Building was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. This facility will be surveyed as two separate buildings. The Janesville Nursing Home, 2008 addition is a NEW 1-story building. The 2008 addition was determined to be of Type II (111) construction. The building is fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 45 beds and had a census of 39 at the time of the survey.	K 000		

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

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 6056

February 28, 2012

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5440022

Dear Mr. Madel III:

The above facility was surveyed on February 13, 2012 through February 16, 2012 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 12 Civic Center Plaza Suite #2105 Mankato Minnesota 56001. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Maria King, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (507) 206-2731 Fax: (507) 344-2723

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00681	A. BUILDING _____ B. WING _____	02/16/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On February 13, 14, 15, and 16th surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00681	A. BUILDING _____ B. WING _____	02/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Continued From page 1 Certification Program; 12 Civic Center Plaza, Suite 2105, Mankato, Minnesota 56001.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 530	MN Rule 4658.0300 Subp. 4 Use of Restraints Subp. 4. Decision to apply restraint. The decision to apply a restraint must be based on the comprehensive resident assessment. The least restrictive restraint must be used and incorporated into the comprehensive plan of care. The comprehensive plan of care must allow for progressive removal or the progressive use of less restrictive means. A nursing home must obtain an informed consent for a resident placed in a physical or chemical restraint. A physician's order must be obtained for a physical or chemical restraint which specifies the duration and circumstances under which the restraint is to be	2 530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00681	A. BUILDING _____ B. WING _____	02/16/2012

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2 530	Continued From page 2 used, including the monitoring interval. Nothing in this part requires a resident to be awakened during the resident's normal sleeping hours strictly for the purpose of releasing restraints. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to use the least restrictive device for the least amount of time for 1 of 3 residents (R24) in the sample who utilized a lap belt in his wheelchair that prevented him from transferring from the wheelchair independently. Findings include: R24 was observed restrained with a lap belt that was not used the least amount of time possible. During initial observations at 1:45 p.m. on 2/13/12, R24 was observed seated in his wheelchair in his room with a lap belt across his lap. The belt had a push button release on it. During observation of cares on 2/14/12 at 12:30 p.m., R24 was observed seated in the dining room at the table in his wheelchair with a lap belt across his lap. During the observation Registered Nurse (RN)-B sat directly beside R24 and assisted him to eat. R24 continued to have his lap belt across his lap. At 12:58 p.m. on 2/14/12, R24's wife was interviewed about the lap belt. She stated R24 was unable to remove the belt independently. She stated, "Thank God he cannot remove it or he would try to get up and fall. That keeps him from being able to get up without help. He used to fall a lot until I was moved into his room with him.	2 530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 530	Continued From page 3 Now I can keep an eye on him." She verified R24 was able to attempt to transfer independently and verified the belt restricted his ability to exit the wheelchair. During observation of morning cares at 6:45 a.m. on 2/15/12, R24 was observed seated in his wheelchair in his room with a seat belt across his lap. He was also noted to have a chair alarm attached to his shirt sleeve. At 8:20 a.m. R24 was observed seated at the dining room table in his wheelchair with the lap belt across his lap. During the observation he was being assisted with eating with nursing assistant (NA)-A sitting directly beside him. At 10:30 a.m. on 2/15/12 RN-A was interviewed and stated R24's wife requested he have the belt on when up in his chair. She stated she was not sure how appropriate it is now because she was unsure if he could still transfer independently. RN-A stated R24 would probably be able to self transfer but it would not be safe. She also stated she had never observed him to be able to independently remove the belt. R24's Physical Restraint Assessment dated 10/21/11, identified he had 2 1/2 side rails to assist with repositioning. The assessment also identified he had, "Physical alarms, tray table or lap buddy -more restrictive." Use for the devices was identified as "necessary due to a history of falls, confusion, and cognitive deficit related to dementia." The assessment further identified when R24 used alarms he continued to fall thus the seat belt was " least restrictive (lap buddy or tray table)." R24's Care Plan for Fall Risk dated 12/15/11, identified him at risk for injury related to falls.	2 530		

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2 530	Continued From page 4 Interventions were identified as follows: Call light within reach, assist with ambulation, 1/2 rails on bed to aid in bed mobility and repositioning, personal alarm, floor alarm and floor mat, scoop mattress in bed, Wanderguard, personal wheelchair with seat belt. Use seat belt when up in chair per family request. EZ stand lift for transfers. During an interview with the director of nursing (DON) at 10:00 a.m. on 2/16/12, she stated R24 wore the seatbelt to prevent him from attempting to transfer independently. She stated if he attempted to transfer without it he would likely fall. When asked if he needed to utilize the restraint when he was in direct observation by staff, the DON stated she had never made the recommendation for staff to remove the restraint when they were directly supervising the resident. The facility failed to utilize R24's restraint in a manner where it was the least restrictive device for the least amount of time. The facility had no plan to remove the device at times when the resident was in direct observation of staff to include meal and activity times. The resident was identified to use the device to prevent unsafe independent transfers. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could develop policies and procedures to ensure residents were comprehensively assessed for the use of restraints. The director of nursing or her designee could educate all appropriate staff members on the processes. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one	2 530		

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2 530	Continued From page 5 (21) Days	2 530		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by: Based on observation, interview and document	2 540		

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2 540	Continued From page 6 review, the facility failed to comprehensively assess 1 of 3 residents (R24) in the sample for wheelchair positioning needs. Findings include: The facility failed to complete a comprehensive assessment of R24's wheelchair positioning needs during his annual review. During observation of resident cares at 8:13 a.m. on 2/14/12, R24 was observed to be wheeled into the dining room from his room by his wife. During the observation R24's feet were noted to be dragging along the floor while being wheeled. The dragging of his feet was audible from approximately 20 feet away. At 8:45 a.m. on 2/14/12, R24 was wheeled back to his room and he was noted to have his feet dragging on the floor. During observation of R24 in his wheelchair in his room at 9:00 a.m. on 2/15/12, he was noted to be sitting in his wheelchair with his pelvis forward and his knees bent upward. His wheelchair was observed to be too short for him and he was mal-positioned while seated. During observation of cares on 2/15/12, at 8:00 a.m. and again at 11:58 a.m., R24 was wheeled from his room to the dining room and back with his feet dragging on the floor each time. R24's annual Minimum Data Set (MDS) assessment, dated 12/2/11, identified he needed extensive assistance of 1 staff with transfers, and as being unable to ambulate. At 10:20 a.m. on 2/15/12, the facility physical therapist (PT) was asked to look at R24's positioning with the surveyor. The PT entered R24's room and looked at his wheelchair	2 540		

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2 540	Continued From page 7 positioning and stated R24 was not seated well. She stated upon initial observation it appeared R24 would benefit from a wheelchair that was higher. She further stated R24 should have foot rests on his chair to keep his feet from going back under chair when staff were assisting him to destinations. She stated R24 might benefit from a different cushion to keep his buttocks back in chair. The PT verified staff had not made a recommendation for an evaluation of R24's wheelchair positioning and verified his positioning could be improved. During interview with registered nurse (RN)-A on 2/15/12, at 2:00 p.m. she stated there had not been any referrals made for wheelchair positioning for R24 and stated the family had brought the chair for the resident and wanted him to use it. RN-A stated there had been no discussion with the family related to R24's positioning in his wheelchair. R24 failed to have his wheelchair positioning needs assessed to accommodate good wheelchair positioning and safety while being wheeled in his wheelchair. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and revise policies and procedures pertaining to full comprehensive resident assessments to assure they comply with the regulations, retrain staff and develop a monitoring procedure. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 540		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review	2 550		

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2 550	Continued From page 8 Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to reassess 1 of 3 residents (R15) in the sample who had inadequate foot support when seated in his wheelchair. Findings include: The facility failed to complete a reassessment for wheelchair positioning for R15 during his quarterly review. During observation of resident cares at 11:33 a.m. on 2/14/12, R15 was observed to be wheeled down the hallway from his room to the dining room by a dietary assistant. His feet were observed dragging on the floor and could be heard scraping against the floor. R15 was noted to be wearing black dress shoes and his wheelchair lacked any foot rests to support his feet while being wheeled in his wheelchair. During observation of R15 on 2/15/12 and 2/16/12 a nursing assistant wheeled the resident to the breakfast and noon meals. The resident's feet were noted to be slightly back under the wheelchair and his feet could be heard dragging across the floor during these times of transport. On all observations, there were no foot rests on R15's wheelchair.	2 550		

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2 550	Continued From page 9 R15's quarterly Minimum Data Set (MDS) assessment dated 12/30/11, identified the resident as dependent on staff for mobility and needing extensive assistance of 1 to 2 staff with transfers and ambulation. During an interview with registered nurse (RN)-A at 12:15 p.m. on 2/16/12, she stated R15 had been in his current chair for approximately 3 months. She stated nursing was responsible to assess wheelchair needs and stated the facility recently had contracted a new therapy service which could be utilized to assess wheelchair positioning. RN-A verified R15 did not propel himself in his wheelchair and stated he should have foot rests on his chair when being wheeled. She verified there had not been an assessment of his wheelchair positioning or referrals made to therapy. The facility failed to reassess R15's mobility and positioning needs while being wheeled in his wheelchair. SUGGESTED METHOD OF CORRECTION: The administrator and the director of nursing (DON) or her designee could develop policies and procedures to ensure comprehensive assessments are completed at the time of the quarterly MDS. The DON or her designee could educate all appropriate staff on these policies and procedures. The DON or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development	2 555		

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2 555	Continued From page 10 Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to develop a comprehensive care plan for 1 of 3 residents (R40) to meet the resident's medical and nursing needs. Findings include: R40's plan of care did not identify the potential for repeated bruising. R 40 was admitted to the facility on 8/8/11 with diagnoses that included: anemia and thrombocytopenia. Review of the nursing notes for R40 identified repeated incidents of bruising and sometimes the bruising was extensive in nature and involved multiple areas of his body. The plan of care identified only the risk for skin breakdown, but failed to include the potential for	2 555		

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2 555	Continued From page 11 bruising. The skin care approached included to monitor his skin daily with AM (morning) and PM (evening) care and with weekly w/p (whirlpool) bath. Notify charge nurse and MD (medical doctor) as appropriate for changes in skin condition. During interview at 11:15 a.m. on 2/16/12, with nursing assistant (NA)-C, verified that R40's skin is inspected daily in the morning but because the staff is so busy, NA-C verified that she really didn't notice anything abnormal related to R40's repeated bruising. During interview with registered nurse (RN)-B at 11:20 a.m.on 2/16/12, she was questioned whether R40's skin bruises frequently and easily, RN-B replied, "oh my, yes!" RN-B further added that if R40's skin is slightly red one day it will be black and blue the next day. During interview with the RN MDS (Minimum Data Set) Coordinator at 2:10 p.m.on 2/15/12, verified that the plan of care for R40 did not identify the potential for bruising related to the diagnosis of thrombocytopenia. Therefore no interventions had been developed to help prevent additional bruising. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could provide education for the licensed staff regarding the importance of developing individualized plans related to prevention of bruising. The Director of Nursing could randomly audit resident charts to ensure the plans of care were completed appropriately. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 555		

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2 570	Continued From page 12	2 570		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to revise the plan of care to include non-pharmacological interventions related to the use of psychoactive medications for 1 of 3 residents (R30) residents reviewed in the sample. Findings include: R30 received Klonopin (anti-anxiety medication) 0.5 mg (milligrams) by mouth twice a day as needed for anxiety. The plan of care lacked any non-pharmacological interventions. R30 was admitted to the facility on 4/10/2009 and current diagnoses include: dementia with behavioral issues; depression and anxiety/agitation. R30's physician orders indicated the PRN Klonopin had been initiated on 1/31/12. The resident's plan of care indicated the resident utilized psychoactive medications, however no	2 570		

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2 570	Continued From page 13 non-pharmacological interventions had been developed for staff to utilize prior to using the PRN Klonopin. During interview with the registered nurse/MDS (Minimum Data Set) Coordinator at 10:30 a.m. on 2/15/12, she verified that the plan of care had not been revised to include any non-pharmacological interventions to be used prior to giving the PRN Klonopin. SUGGESTED METHOD OF CORRECTION: The director of nursing could develop a system to educate staff and develop a monitoring system to ensure staff are reviewing and revising the care plan as indicated in order to provide appropriate care and services. The Director of Nursing could develop and implement a random audit tool to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		

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2 830	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide appropriate care and services for non-pressure related skin conditions for 1 of 3 residents (R8) in the sample who was reviewed for non pressure related skin issues. Findings include: The facility failed to assess and monitor for change, skin anomalies on the face and neck of R8. During observation of R8 at 4:52 p.m. on 2/13/12, she was noted to have multiple growths on the dermis of the left side of her face and neck. She was also noted to have growths on the dermis of her nose, forehead and right neck region. The areas were of differing sizes, dark, irregular edged, and protruded from the dermis. During an interview with registered nurse (RN)-B at 3:00 p.m. on 2/14/12, she stated the areas on R8's face and neck appeared to be large, irregular shaped moles or skin tags. RN-B stated there had been discussion with the resident and her physician about having the areas removed however, R8 had refused. RN-B stated she did not recall when the discussion occurred with the R8. R8's active care plan for skin, dated 2/2/12, identified she was at risk for skin breakdown. She was identified to have her skin monitored daily with a.m. (morning) and p.m. (evening) cares and weekly with her bath. Her care plan identified changes should be reported to the charge nurse	2 830		

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2 830	Continued From page 15 as needed. The care plan addressed areas on her feet and pressure ulcer risk but did not identify the anomalies on her face and neck. During review of R8's medical record at 8:00 a.m. on 2/15/12, there was no documentation to indicate that assessment and ongoing monitoring were completed related to the anomalies of the skin for R8. At 9:51 a.m. on 2/15/12, RN-A was interviewed in reference to R8's skin condition. RN-A stated the nursing assistants (NA) reviewed resident skin during a.m. and p.m. cares and would let the nurses know if there was a concern. RN-A was asked if there was any monitoring conducted for R8's skin outside of pressure ulcer risk. She confirmed that no assessment to monitor the size or characteristics of the moles/skin tags was completed. The facility conducted a skin assessment on 1/23/12 that identified R8's skin as intact and identified her with venous stasis ulcers on legs. The assessment lacked any identification of the areas noted on R8's face and neck. When RN-A was asked how she would identify changes in skin condition if not comprehensively assessed to establish a baseline, she stated, "Good question." The facility failed to complete necessary assessment and monitoring for R8's skin to identify if there were significant changes in the areas of growth on her face and neck region. R8 had large, brown, and irregular shaped skin tags/moles that lacked ongoing monitoring to identify progression. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could review and reeducate all staff on the policies and	2 830		

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2 830	Continued From page 16 procedures to ensure that all resident's health issues are properly monitored. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21000	MN Rule 4658.0610 Subp. 4 Dietary Staff Requirements-Hygiene. Subp. 4. Hygiene. Dietary staff must thoroughly wash their hands and the exposed portions of their arms with soap and warm water in a hand washing facility before starting work, during work as often as is necessary to keep them clean, and after smoking, eating, drinking, using the toilet, or handling soiled equipment or utensils. Dietary staff must keep their fingernails clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to serve food under sanitary conditions which had the potential to affect all 39 residents residing in the facility. Findings include: Food was not served under sanitary conditions. During observation of the preparation and serving of breakfast on 2/16/12 at 7:25 a.m., Cook -A was observed to wear gloves while serving breakfast. Cook-A picked up the handle of a milk carton and poured a glass of milk. With the same gloved hands she took a cooked egg out of a paper wrapper, touching the egg with her gloved	21000		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21000	Continued From page 17 hand. Cook-A then picked up the handle of the milk carton and poured another glass of milk. With the same gloved hands Cook-A took half a banana, pealed it with a knife and handled the half banana (without the skin) with her same gloved hands and placed it onto a plate. During interview at 7:40 a.m. on 2/16/12, Cook-A verified that the above practices constituted a break in infection control. During interview with the certified dietary manager at 7:45 a.m. on 2/16/12, she verified that all dietary staff had been educated on how to handle, prepare and serve foods using proper infection control practices. She confirmed the above scenario did not consitute proper infection control technique. During observations at 7:45 a.m. on 2/16/12, a sign was noted to be mounted above the hand washing sink in the kitchen with the following direction: "...Hands must be washed between any contamination .....that means touching anything that could be contaminated. Gloves may be placed on clean hands but gloves get contaminated the same as hands. Change Often. When contaminated, gloves must be removed, hands rewashed and gloves reapplied." SUGGESTED METHOD OF CORRECTION: The director of dietary services could develop a policy and procedure to ensure that food was served in a safe manner. Staff could receive training regarding handwashing and glove use to ensure knowledge of safe food handling while serving residents. Monitoring could occur to ensure food was served in a safe and sanitary manner.	21000		

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	00681	A. BUILDING _____ B. WING _____	02/16/2012

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21000	Continued From page 18 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21000		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is	21530		

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21530	Continued From page 19 the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to assure that drug regimen irregularities are reported to the attending physician and the director of nursing for 2 of 10 (R35 and R1) residents reviewed who received anti-psychotic medications without attempts of a gradual dose reduction or documented clinical rationale why a dose reduction would be contraindicated. The Findings include: R35 received psychotropic medications and lacked clinical indications for use and monitoring of the medications effectiveness. The pharmacist failed to identify these irregularities. R35's record was reviewed and revealed the resident had been admitted to the facility 3/7/11 with diagnoses that included Alzheimer's dementia and anxiety. A review of the nurses' notes and behavior monitoring flow sheets indicated the resident exhibited behaviors including: hitting, biting, kicking and swearing at staff. A quarterly MDS (minimum data set) assessment dated 9/9/11 revealed the resident was cognitively impaired and exhibited physical behaviors including hitting, kicking, and scratching on a daily basis. Verbal behaviors exhibited included screaming and swearing 4-6 days a week, but not daily. A quarterly MDS dated 12/9/11 also revealed the resident was cognitively impaired and exhibited physical and verbal	21530		

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21530	Continued From page 20 behavioral symptoms. However the physical behaviors had occurred only 4-6 days a week, and the verbal behavioral symptoms had only occurred 1-3 days a week. A review of the resident's physician orders and medication administration records revealed the resident had utilized Seroquel 25 mg (milligrams) daily, and Risperdone 1.5 mg daily since admission. However, there had been no documented clinical indication or diagnoses for the use of these medications. On 3/15/11 a pharmacist's drug regimen review questioned the need for 2 antipsychotics and whether or not the Seroquel could be decreased to 12.5 mg in an effort to taper off the use of the medication. The physician's documented response included, "Yes (regarding the use of 2 antipsychotics), No tapering." A pharmacist's review from 4/19/11 indicated "2nd Notice" and included the same questions. The physician's documented response was dated 6/30/11 and included, "Seroquel decreased." On 10/18/11 the pharmacist's drug regimen review identified that Sinemet 25/100 mg three times per day had been initiated for Parkinsonism symptoms on 10/14/11. The pharmacist had documented that the symptoms may be due to the antipsychotic therapy, identifying the resident received both Risperdone and Seroquel, both of which are known to cause Parkinsonism with Risperdone having a higher overall incidence. The pharmacist had recommended discontinuation, dose reduction, or alternative antipsychotic agent be used if appropriate. The physician response was dated 2/16/12 which included, "continue meds." There was no further clinical justification documented regarding risks and/or benefits for continued use of the antipsychotic medications at	21530		

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21530	Continued From page 21 current dosages. Registered nurse (RN)-A was interviewed at 1:15 p.m. on 2/15/12. She verified the resident's record failed to specifically indicate indications for use or relevant diagnosis for the use of the Risperdone and Seroquel. In addition, RN-A stated no GDR had been attempted on the Risperdone, and the Seroquel dose had remained the same since 6/30/11. The pharmacist verified at 11:24 a.m. on 2/16/12 that no relevant diagnosis or specific clinical indications had been documented by the physician for the use of the Risperdone and Seroquel. He confirmed he had never addressed this with the physician. R1 received psychotropic medications and lacked clinical rational for continued use of the medication. In addition, there had been no attempts at dose reduction. R1 was admitted to the facility on 10/23/00 with diagnoses that included: mental retardation; depressive disorder and histrionic personality disorder. Review of R1's physician orders identified that Effexor XR (an antidepressant) 150 mg (milligrams) daily was initiated on 3/18/08. The consulting pharmacist's recommendation dated 3/15/11, identified the following notation: Please review the Effexor 150 mg for a dose reduction if appropriate. No reduction attempted upon last review of 9/10 due to history of failed dose reductions. If no reduction appropriate, please document the clinical rationale." The attending physician's documented response dated 4/19/11 included: "Continue same doses of Effexor XR and Resperidone."	21530		

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21530	Continued From page 22 There was no documented clinical justification for continued use, or for the lack of dose reduction. However, the pharmacist had made no further recommendations related to this. The director of nursing (DON) was interviewed at 11:30 a.m. on 2/16/11. The DON verified that no clinical rational could be found in the medical record related to the continued use, same dosage, or lack of dose reduction for the psychoactive medication. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could assign the interdisciplinary team to review the appropriateness of current medications for all residents, and refer any concerns to the attending physician and/or the consulting pharmacist. The quality assurance committe could randomly audit residents' drug regimens to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If	21540		

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21540	Continued From page 23 the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to adequately identify, assess, and monitor clinical indications for continued use of medications for 2 of 10 residents (R35 and R1) in the sample whose medications were reviewed. The Findings include: R35 received psychotropic medications and lacked clinical indications for use and monitoring of the medications effectiveness. R35's record was reviewed and revealed the resident had been admitted to the facility 3/7/11 with diagnoses that included Alzheimer's dementia and anxiety. A review of the nurses' notes and behavior monitoring flow sheets indicated the resident exhibited behaviors including: hitting, biting, kicking and swearing at staff. A quarterly MDS (minimum data set) assessment dated 9/9/11 revealed the resident was cognitively impaired and exhibited physical behaviors including hitting, kicking, and scratching on a daily basis. Verbal behaviors exhibited included screaming and swearing 4-6 days a week, but not daily. A quarterly MDS dated 12/9/11 also revealed the resident was cognitively	21540		

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21540	Continued From page 24 impaired and exhibited physical and verbal behavioral symptoms. However the physical behaviors had occurred only 4-6 days a week, and the verbal behavioral symptoms had only occurred 1-3 days a week. A review of the resident's physician orders and medication administration records revealed the resident had utilized Seroquel 25 mg (milligrams) daily, and Risperdone 1.5 mg daily since admission. However, there had been no documented clinical indication or diagnoses for the use of these medications. On 3/15/11 a pharmacist's drug regimen review questioned the need for 2 antipsychotics and whether or not the Seroquel could be decreased to 12.5 mg in an effort to taper off the use of the medication. The physician's documented response included, "Yes (regarding the use of 2 antipsychotics), No tapering." A pharmacist's review from 4/19/11 indicated "2nd Notice" and included the same questions. The physician's documented response was dated 6/30/11 and included, "Seroquel decreased." On 10/18/11 the pharmacist's drug regimen review identified that Sinemet 25/100 mg three times per day had been initiated for Parkinsonism symptoms on 10/14/11. The pharmacist had documented that the symptoms may be due to the antipsychotic therapy, identifying the resident received both Risperdone and Seroquel, both of which are known to cause Parkinsonism with Risperdone having a higher overall incidence. The pharmacist had recommended discontinuation, dose reduction, or alternative antipsychotic agent be used if appropriate. The physician response was dated 2/16/12 which included, "continue meds." There was no further clinical justification documented regarding risks and/or benefits for	21540		

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21540	Continued From page 25 continued use of the antipsychotic medications at current dosages. Registered nurse (RN)-A was interviewed at 1:15 p.m. on 2/15/12. She verified the resident's record failed to specifically indicate indications for use or relevant diagnosis for the use of the Risperdone and Seroquel. In addition, RN-A stated no GDR had been attempted on the Risperdone, and the Seroquel dose had remained the same since 6/30/11. R1 received psychotropic medications and lacked clinical rational for continued use of the medication. R1 was admitted to the facility on 10/23/00 with diagnoses that included: mental retardation; depressive disorder and histrionic personality disorder. Review of R1's physician orders identified that Effexor XR (an antidepressant) 150 mg (milligrams) daily was initiated on 3/18/08. The consulting pharmacist's recommendation dated 3/15/11, identified the following notation: Please review the Effexor 150 mg for a dose reduction if appropriate. No reduction attempted upon last review of 9/10 due to history of failed dose reductions. If no reduction appropriate, please document the clinical rationale." The attending physician's documented response dated 4/19/11 included: "Continue same doses of Effexor XR and Resperidone." There was no documented clinical justification for continued use, or for the lack of dose reduction. The director of nursing (DON) was interviewed at 11:30 a.m. on 2/16/11. The DON verified that no	21540		

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21540	Continued From page 26 clinical rational could be found in the medical record related to the continued use, same dosage, or lack of dose reduction for the psychoactive medication. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could review the need for medication monitoring with the licensed staff including the State and federal regulations. She could randomly audit resident medication orders to ensure that medications were utilized in accordance with accepted standards, and to ensure medications were monitored for potential adverse effects. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to store drugs and biologicals per manufacturer's storage recommendations in 1 of 1 medication rooms which had the potential to affect all 39 residents. Findings include: During inspection of the facility's medication storage room at 11:50 a.m. on 2/16/12, the refrigerator containing facility medications	21610		

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21610	Continued From page 27 requiring refrigeration was observed. The refrigerator was noted to contain 1 vial of multi-dose Tuberculin purified protein derivative (PPD), 11 syringes of Hepatitis B vaccine, and 1 vial of multi-dose Influenza vaccine. The 3 items were located directly under the freezer compartment of the refrigerator and the boxes the items were stored in were noted to be wet and frozen. The solutions inside of the vials and syringes remained in liquid form but there was ice noted inside the containers and on the glass surfaces. The refrigerator thermometer recorded a temperature of 31 degrees Fahrenheit (F) when it was initially inspected. The manufacturer's literature indicated the Hepatitis vaccine was to be stored between 35-46 degrees F. It indictated the vaccine could lose potentancy when frozen. The manufacturer's literature indicated the Influenza vaccine be stored at 35-46 degrees F and should not be frozen. The manufacturer's literature indicated the Tuberculin PPD should be stored at 35-46 degrees F and should not be frozen. During interview with the Consulting Pharmacist at 12:48 p.m. on 2/16/12, he verified the medications would no longer be appropriate for use as they were stored below the manufacturer's recommended temperature. SUGGESTED METHOD FOR CORRECTION: The director of nursing and/or designee could review appropriate policies and procedures to provide safe storage of medications in the medication refrigerator. The staff could be monitored to assure that staff are monitoring temperatures for safe storage.	21610		

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21610	Continued From page 28 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21610		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a resident's environment was as free of accident hazards as possible for 1 of 3 residents (R40) reviewed who utilized side rails. Findings include: The facility failed to ensure R40's siderails were safe prior to use by the resident. R40 had been admitted to the facility on 8/8/11 with diagnoses including: Osteoarthrosis; asthma; acute gouty arthritis; rheumatoid arthritis; anemia and thrombocytopenia. During an observation of the resident's environment on 2/13/12 at 2:30 p.m., and again on 2/14/12 at 9:23 a.m., the resident's bed was noted to have half side rails in the up position on the outer sides of the bed. The rails were noted to be loose, moving easily side to side and front to back when physically touched. During observations of R40 at 6:35 a.m.on 2/15/12 during morning cares, the resident was	21665		

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21665	Continued From page 29 observed to utilize the siderails to assist with mobility. The resident grasped the outer side rail with his right arm and pulled himself up putting pressure on the outer side rail. Review of the nursing notes revealed an incident had occurred for R40 on 12/29/11 at 4:15 am. According to the documentation, nursing staff had heard a strange sound about 4:15 a.m. and had found R40 in bed rolled onto his right side, legs out of bed, right arm down along his side on the bed, and his face and chest leaning into the siderail. Documentation indicated the resident's speech was thick and hard to understand. The resident had been incontinent of bowel. The documentation also indicated R40 had made no attempts to put his light on even though he normally did so when he needed something. At the time of the incident, R40 was observed to have had a bruise on his right shoulder that extended to his back and right scapular area extending down to his lower rib cage. A BIMS (Brief Interview of Mental Status) had been completed for R40 on 2/9/12, and identifed the resident had scored 15/15 which indicated the resident had no problems with short or long term memory. During an interview with R40 at 4:50 p.m. on 2/14/12, he stated he did not remember the incident from 12/29/11. R40 stated he did not think he had gotten injured, and stated he did not remember having received any bruising as a result of the incident. R40 stated he had noticed that the side rails were very loose in the past, but stated that he had never really known what they were supposed to be like. The record included a Restraint Assessment for	21665		

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21665	Continued From page 30 R40 dated 8/8/11 that indicated the resident utilized 2 half siderails when in bed to aid with bed mobility after a left hip replacement. No further assessment of the siderails, including safe use, had been conducted. The director of nurses (DON) was interviewed on 2/14/12 at 3:41 p.m. She stated she had been unaware of the incident from 12/29/11 when R40 had rolled into his side rail. She confirmed that although an incident report had been completed by LPN (licensed practical nurse)-C following the incident, the report had not been forwarded to her for review. The DON verified no investigation into the incident had been conducted because she had not been aware of it. She confirmed there had been no additional assessment of the resident's siderails following the incident either. The DON stated that had she been informed of the incident, she probably would have come in and spoken to the resident to determine what had happened. She said LPN-C should have contacted her because that was the way their system routinely worked. When questioned about how they assessed siderails for safety, the DON stated their maintenance man measured all the siderails in the building. The DON confirmed no other mobility device, such as a grab bar, had been assessed for this resident's use. LPN-C was interviewed by telephone on 2/14/11 at 4:24 p.m., she confirmed the details of the incident as described above for R40. LPN-C stated that at the time of the 12/29/11 incident, R40 had rolled into, and basically was hugging, the side rail on his right side with his upper torso against the side rail with his legs out of the bed and his buttocks still on the bed. She said his left arm had been positioned between the bed and the siderail and his right arm was wrapped	21665		

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	00681	A. BUILDING _____ B. WING _____	02/16/2012

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

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21665	Continued From page 31 around the outer siderail. LPN-C stated that when R40 gets up "he normally leans against and grasps the siderail to to sit up. When we heard the noise coming from his room he was already in the process of getting up. He was putting alot of pressure on the side rail as he routinely pushes and pulls when he gets up." LPN-C also stated she had filled out an incident report and then it was kept at the desk. She stated, "I didn't call the DON as he didn't hit his head." During an additional interview with LPN-C at 6:30 a.m. on 2/15/12, she stated she had noticed that R 40's outer siderails were loose in the past but had never reported it to anybody. She stated she'd previously noticed that the outer side rail "flexed" when R40 attempted to sit up. The resident's side rails were observed to have been removed, and replaced by rails that did not move or flex on 2/14/12 at 4:30 p.m. SUGGESTED METHOD FOR CORRECTION: The director of nursing and director of maintenance could review and revise policies and procedures regarding side rail safety. The director of maintenance could revise the preventative maintenance schedule to assure that side rails were assessed for proper fit on resident beds. The director of maintenance could monitor on an ongoing basis to identify new concerns as they arise and could report to the quality assurance committee and safety committees as appropriate. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights	21810		

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21810	Continued From page 32 Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to provide accommodations for adequate wheelchair positioning for 2 of 3 residents (R24 and R15) in the sample reviewed for positioning needs. Findings include: The facility failed to provide adequate wheelchair positioning and foot rests for R24. During observation of resident cares at 8:13 a.m. on 2/14/12, R24 was observed to be wheeled into the dining room from his room by his wife. During the observation R24's feet were noted to be dragging along the floor while being wheeled. The dragging of his feet was audible from approximately 20 feet away. At 8:45 a.m. on 2/14/12, R24 was wheeled back to his room and he was noted to have his feet dragging on the floor. During observation of R24 in his wheelchair in his room at 9:00 a.m. on 2/15/12, he was noted to be sitting in his wheelchair with his pelvis forward and his knees bent upward. His wheelchair was observed to be too short for him and he was mal-positioned while seated.	21810		

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21810	Continued From page 33 During observation of cares on 2/15/12, at 8:00 a.m. and again at 11:58 a.m., R24 was observed to have been wheeled from his room to the dining room, and back, with his feet dragging on the floor each time. At 10:20 a.m. on 2/15/12, the facility's physical therapist (PT) was asked to look at R24's positioning with the surveyor. The PT entered R24's room and looked at his wheelchair positioning and stated R24 was not positioned well. The PT stated upon initial observation it appeared R24 would benefit from a wheelchair that was higher, and further stated R24 should have foot rests on his chair to keep his feet from going back under the chair when staff were assisting him to destinations. She stated R24 might benefit from a different cushion to keep his buttocks back in chair. The PT verified staff had not made a recommendation for an evaluation of R24's wheelchair positioning and verified his positioning could be improved. During interview with registered nurse (RN)-A on 2/15/12 at 2:00 p.m., she stated there had not been any referrals made for wheelchair positioning for R24 and stated the family had brought the chair in for the resident and wanted him to use it. RN-A also stated there had been no discussion with the family related to his positioning in his wheelchair. R24 failed to have his wheelchair positioning needs assessed to accommodate good wheelchair positioning and safety while being wheeled in his wheelchair. The facility failed to provide adequate wheelchair positioning for R15.	21810		

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21810	Continued From page 34 During observation of resident cares at 11:33 a.m. on 2/14/12, R15 was observed to be wheeled down the hallway from his room to the dining room by a dietary assistant. His feet were observed dragging on the floor and could be heard scraping against the floor. R15 was noted to be wearing black dress shoes and his wheelchair lacked any foot rests to support his feet while being wheeled in his wheelchair. During observation of R15 on 2/15/12 and 2/16/12 a NA wheeled the resident to the breakfast and noon meals. The resident's feet were noted to be slightly back under the wheelchair and his feet could be heard dragging across the floor during these times of transport. On all observations, there were no foot rests on R15's wheelchair. During an interview with RN-A at 12:15 p.m. on 2/16/12, she stated R15 had been in his current chair for approximately 3 months. She stated nursing was responsible to assess wheelchair needs and stated the facility recently had contracted a new therapy service which could be utilized to assess wheelchair positioning. RN-A verified R15 did not propel himself in his wheelchair and stated he should have foot rests on his chair when being wheeled. She verified there had not been an assessment of his wheelchair positioning or referrals made to therapy. The facility failed to reassess and provide adequate mobility and positioning for R15 while being wheeled in his wheelchair. SUGGESTED METHOD FOR CORRECTION: The director of nursing or physical therapist could establish procedures to ensure residents have	21810		

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21810	Continued From page 35 adequate equipment necessary for proper and safe positioning. The could educate staff regarding proper equipment use and could randomly audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement	21980		

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21980	Continued From page 36 agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to investigate and report injuries of unknown origin in accordance with the 'Facility Prevention of Maltreatment Policy and Procedure' for 1 of 1 resident (R40) in the sample who sustained injuries of unknown origin. Findings include: The facility failed to complete an investigation into a bruise of unknown origin for R40 and failed to report the injury to officials in accordance with State law. R40's medical record was reviewed. The Nurse Progress Notes dated 11/27/11, indicated the resident had a "5 inch by 3 inch red to purple bruise on his right upper back. [R40] denies pain,	21980		

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21980	Continued From page 37 no swelling or drainage, and he doesn't remember doing anything to it but said he could have bumped it getting in and out of the car when he went out with family 2 days ago." The note also identified R40 as having "several bruises on his front side also." R40's care plan dated 8/25/11, identified he needed extensive assistance of 2 staff with transfers and sometimes required the use of an EZ stand (mechanical lift device) to transfer. The facility maintained a log that tracked incidents. An entry for 11/27/11, at 7:30 p.m. identified R40 with a bright purple, red bruise on his right back shoulder that measured 5 x 3 inches. The cause of the injury was documented as unknown and staff documented he could have bumped it when out of the building. R40's quarterly Minimum Data Set (MDS) assessment dated 10/5/11, identified him with a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. However, R40's nurses' notes identified he had been experiencing episodes of lethargy and confusion and was unable to respond appropriately to questions at times. The MDS identified R40 as requiring extensive assistance of 2 staff with transfers, dressing, toileting and identified he was unable to ambulate. During interview with the director of nursing (DON) at 2:10 p.m. on 2/16/12, she verified the injury was of unknown origin. The DON confirmed she had not investigated the injury to rule out abuse and verified there had been no report made to outside agencies related to the injury.	21980		

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21980	Continued From page 38 The Facility's Prevention of Maltreatment Policy and Procedure dated 1/2011, identified all allegations of suspected maltreatment would be immediately reported to the administrator who would immediatley notify the DON. There was no documentation to indicate that the administrator or DON had received a report related to R40's bruising of unknown origin from 11/27/11. The facility's policy also indicated when reporting to outside agencies the facility DON, administrator, or social worker would immediately make a telephone report to the Vulnerable Adult Worker for Waseca County. The policy then identified, for incidents that are reportable by State guidelines, the Common Entry Point (CEP) must be notified within 24 hours of the discovery of the incident. For incidents reportable to meet federal guidelines, the facility will send an initial report to the Minnesota Department of Health within 24 hours of discovery of the incident. However, no report of the injury of unknown origin for R40 had been made to officials in accordance with State law. For injuries of unknown origin the DON stated the facility utilized the Care Providers of Minnesota guidance; Version 1.3, dated 8/8/08. This guidance included, "An injury should be classified as an injury of unknown source when both of the following conditions are met: 1. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident. 2. The injury was suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time or the incidence of injuries over time."	21980		

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21980	Continued From page 39 The facility failed to report and investigate an injury of unknown origin for R40. The notes identified R40 required extensive assistance of staff to transfer and ambulate. The incident documentation conclusion was that the cause of the injury on R40's back was potentially caused by bumping it when getting out of a car. However, there was no investigation to identify if services were being provided as directed by the care plan, or if the injury occurred by some other means. Although the resident was able, at times, to communicate his needs, he also experienced episodes of confusion and was unable to recall past events. There was no documentation that the family had been interviewed regarding the resident's outing. There was no documentation provided by the facility to identify a thorough investigation had been conducted to rule out abuse. The facility also failed to report the injury of unknown origin immediately. SUGGESTED METHOD FOR CORRECTION: The administrator, director of nursing (DON), social services or designee(s) could review and revise as necessary the policies and procedures regarding the internal process of reporting/investigating the process of abuse or maltreatment. The administrator, DON, social services or designee (s) could provide training for all appropriate staff on these policies and procedures. The administrator, DON, social services or designee (s) could monitor to assure all reports of abuse are being reported and investigated. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21980		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults	22000		

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22000	Continued From page 40 Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives	22000		

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22000	Continued From page 41 such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to operationalize policies to ensure prompt reporting and investigation of injuries of unknown origin for 1 of 1 residents (R40) in the sample who sustained an injury of unknown origin. Findings include: The facility failed to thoroughly investigate injuries of unknown origin for R40 and failed to report the injury to the administrator and officials in accordance with State law per their policy. R40's medical record was reviewed. The Nurse Progress Notes dated 11/27/11, indicated the resident had a "5 inch by 3 inch red to purple bruise on his right upper back. [R40] denies pain, no swelling or drainage, and he doesn't remember doing anything to it but said he could have bumped it getting in and out of the car when he went out with family 2 days ago." The note also identified R40 as having "several bruises on his front side also." R40's care plan dated 8/25/11, identified he needed extensive assistance of 2 staff with transfers and sometimes required the use of an	22000		

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22000	Continued From page 42 EZ stand (mechanical lift device) to transfer. The facility maintained a log that tracked incidents. An entry for 11/27/11, at 7:30 p.m. identified R40 with a bright purple, red bruise on his right back shoulder that measured 5 x 3 inches. The cause of the injury was documented as unknown and staff documented he could have bumped it when out of the building. R40's quarterly Minimum Data Set (MDS) assessment dated 10/5/11, identified him with a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. However, R40's nurses' notes identified he had been experiencing episodes of lethargy and confusion and was unable to respond appropriately to questions at times. The MDS identified R40 as requiring extensive assistance of 2 staff with transfers, dressing, toileting and identified he was unable to ambulate. The Facility's Prevention of Maltreatment Policy and Procedure dated 1/2011, identified all allegations of suspected maltreatment would be "immediately" reported to the administrator who would immediately notify the DON. There was no documentation to ensure this had occurred. In addition the policy indicated an investigation would be initiated, "The DON, administrator or social worker will contact the necessary individuals (staff, residents, family members, roommate) to ascertain the facts of the report are correct and to add further details. This information will be documented on the incident report." A thorough investigation had not been conducted. The policy also indicated when reporting to outside agencies the facility DON, administrator, or social worker would immediately make a telephone report to the Vulnerable Adult	22000		

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22000	Continued From page 43 Worker for the County. The policy then identified, for incidents that are reportable by State guidelines, the Common Entry Point (CEP) must be notified within 24 hours of the discovery of the incident. For incidents reportable to meet federal guidelines, the facility will send an initial report to the Minnesota Department of Health within 24 hours of discovery of the incident. However, no report of the injury of unknown origin for R40 had been made to officials in accordance with State law. The facility failed to report and investigate an injury of unknown origin for R40. The notes identified R40 required extensive assistance of staff to transfer and ambulate. The incident documentation conclusion was that the cause of the injury on R40's back was potentially caused by bumping it when getting out of a car. However, there was no investigation to identify if services were being provided as directed by the care plan, or if the injury occurred by some other means. Although the resident was able, at times, to communicate his needs, he also experienced episodes of confusion and was unable to recall past events. There was no documentation that the family had been interviewed regarding the resident's outing. There was no documentation provided by the facility to identify a thorough investigation had been conducted to rule out abuse. The facility also failed to report the injury of unknown origin immediately. SUGGESTED METHOD FOR CORRECTION: The director of nurses and the social worker could provide additional education to all staff regarding reporting responsibilities and immediate investigation to ensure implementation of the procedures of the facility's Abuse Prevention Policy. The quality assurance	22000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00681	A. BUILDING _____ B. WING _____	02/16/2012

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

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22000	Continued From page 44 program could randomly audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	22000		