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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: ICHY
Facility ID: 00542

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245594**

2. STATE VENDOR OR MEDICAID NO. (L2) **220043100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GIL-MOR MANOR**
(L4) **96 THIRD STREET EAST**
(L5) **MORGAN, MN** (L6) **56266**

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 **01/09/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **35** (L18)

13.Total Certified Beds **35** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

And/Or Approved Waivers Of The Following Requirements:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	35			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Lois Boerboom, HFE NE II 02/09/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 02/09/2018 (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
11/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

CMS Certification Number (CCN): 245594

February 9, 2018

Ms. Terrie Frank, Administrator
Gil-Mor Manor
96 Third Street East
Morgan, MN 56266

Dear Ms. Frank:

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

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

Effective December 19, 2017 the above facility is certified for:

35 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 35 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

cc: Licensing and Certification File

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered

February 9, 2018

Ms. Terrie Frank, Administrator
Gil-Mor Manor
96 Third Street East
Morgan, MN 56266

RE: Project Number S5594028

Dear Ms. Frank:

On November 29, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 16, 2017. 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 January 9, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on December 18, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 16, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 19, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 16, 2017, effective December 19, 2017 and therefore remedies outlined in our letter to you dated December 1, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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Facility ID: 00542

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(L4) **96 THIRD STREET EAST**
(L5) **MORGAN, MN** (L6) **56266**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **11/16/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)
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2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **12/31**

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From (a) :
To (b) :

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A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	35			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Kathy Sass, HFE NEII 12/12/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/10/2018 (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:

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

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23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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

CCN: 24 5594

On November 13-16, 2017, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH) to determine compliance with requirements at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities.

In addition, An investigation of complaint H5594015 was completed at the time of the survey and was not substantiated.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 1, 2017

Ms. Terrie Rothmeier, Administrator
Gil-Mor Manor
96 Third Street East
Morgan, MN 56266

RE: Project Numbers S5594028, H5594015

Dear Ms. Rothmeier:

On November 16, 2017, 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 electronically delivered CMS-2567, whereby corrections are required. In addition, at the time of the November 16, 2017 standard survey the Minnesota Department of Health completed an investigation of complaint number H5594015 that was found to be unsubstantiated.

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

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

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: gloria.derfus@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 26, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 26, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by February 16, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 16, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING ______ B. WING ______	C 11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL-MOR MANOR	**96 THIRD STREET EAST MORGAN, MN 56266**

(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 On November 13-16, 2017, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH) to determine compliance with requirements at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility's electronic Plan of Correction (ePoC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePoC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the PoC will be used as verification of compliance. An investigation of complaint H5594015 was completed at the time of the survey and was not substantiated.	F 000		
F 157 SS=D	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a	F 157		12/19/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed | TITLE | (X6) DATE 12/08/2017

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
	245594	A. BUILDING ______ B. WING ______	C 11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL-MOR MANOR	**96 THIRD STREET EAST MORGAN, MN 56266**

(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 157	Continued From page 1 deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify family member for 1 of 1 resident (R32) when R32 developed shingles and was started on anti-viral medication.	F 157	Plan of correction: The Administrator and Director of Nursing developed, reviewed and instituted the Resident Notification of Change Policy	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING ______ B. WING ______	C 11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL-MOR MANOR	96 THIRD STREET EAST MORGAN, MN 56266

(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 157	Continued From page 2 Findings include: R32 was admitted to the facility 12/14/15, with admission diagnoses of dementia, anxiety disorder, femur (hip) fracture per the Admission Face Sheet. R32's Care Area assessment dated 4/14/17, indicated R32 had a fluctuating cognitive level and did not always communicate with staff. Staff needed to anticipate R32's needs. Nursing Progress Notes on 10/25/17, at 5:06 a.m. indicated "Rashy pink raised area on left mid abdomen and mid left side." Fax sent to doctor to see what he would suggest for it. On 10/26/17, at 1:49 p.m. a Progress Note indicated R32's medical doctor responded to fax about rash/shingles and ordered Valacyclovir (an anti-viral medication) and also wrote that resident may come out to dining room with lesions covered. On 10/27/16, at 3:00 p.m. a Progress Note indicated "Red areas continue to spread toward the back on his left side and one of the red raised areas had three small blisters on it. Denied pain." On 10/27/17, at 11:53 a.m. A Progress Note "Red areas continue from mid abdomen around to back and approximately 2-2.5"[inches] wide but some areas are spotty and multiple areas have pustules forming or are formed. Area is covered and resident is able to come out to dining room per MD. Valacyclovir was started." On 10/27/17, at 11:55 p.m. the Progress Note read, "Resident did complain of pain this evening and was given his bedtime Tylenol [Acetaminophen - a mild analgesic] at 6:15 p.m. Checked and noted that he has a light red rash on the right side of his abdomen and dark red blistered areas on his left abdomen and back." On 10/28/17, at 8:14 a.m. note text	F 157	and Procedure. Updated staff education materials for new hire orientation and annual education. Educate charge nursing staff and the interdisciplinary team about the Notification of Change Policy and Procedure. Conduct updated training for nursing leaders about supervision and monitoring for change in condition notification requirements. Track notification of changes for residents within our care on the Notification of Changes Tracking Log, noting the following; 1. Resident Name 2. Date 3. Change in condition/altered treatment/transfer/room change with the reason for notification of change 4. Notification of Physician or Physician s delegate; Date/Time/Response 5. Notification of resident and Resident s Representative; Date/Time/Response The Director of Nursing conducted individual education and training to charge nurses which was completed on December 4, 2017. A follow-up interdisciplinary team inservice is scheduled for December 19, 2017. Plan of correction completion date is December 19, 2017. Notification of Change Policy: It is the policy of Gil-Mor Manor that changes in resident s condition or treatment are immediately shared with the resident and /or resident representative, according to their authority, and reported to the attending physician. The resident and/or their representative will be	

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F 157	Continued From page 3 indicated, "Areas continue on Resident and precautions in place. Denies pain at this time." On 10/28/17, at 11:56 a.m., the note read, "Extra Strength Acetaminophen Capsule. Give 2 tablet by mouth every 8 hours as needed for pain." On 11/14/17, at 10:17 a.m. familiy member (F)-1 stated she would be the one notified with a change in condition, but had not received a call when R32 developed shingles. F-1 stated she and her sister really split the duties, her sister had stopped to visit and that's how she found out. F-1 was notified by her sister. On 11/16/17, at 11:04 a.m. the director of nursing stated she thought the family had been notified, had a talk with F-1 about how painful shingles are and Tylenol was scheduled then for a few days. A notification of change policy was requested but not received.	F 157	educated about treatment options and supported to make an informed choice about care preferences when there are multiple care options available. Nurses and other care staff are educated to identify changes in a resident s status and define changes that require notification of the resident and/or their representative, and the resident s physician to ensure best outcomes of care for the resident. Objective of the notification of change policy: The objective of the notification policy is to ensure that the facility staff makes appropriate notification to the physician and delegated non-physician practitioner and immediate notification to the resident and/or the resident representative when there is a change in the resident s condition, or an incident that may require physician intervention. The intent of the policy is to provide appropriate and timely information about changes relevant to a resident s condition or change in room or roommate to the parties who will make decisions about care, treatment, and preferences to address the changes. Procedure: Requirements for notification of resident, the resident representative and their physician. Notification is provided to residents and/or the resident representative(s) to promote the resident s right to make choices about care and treatment and to keep them informed of the resident s current health	

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F 157	Continued From page 4	F 157	status. 1. The nurse will immediately notify the resident, resident s physician and the resident representative for the following (list is not all inclusive): A. An accident involving the resident, which results in injury and has the potential for requiring physician intervention. B. A significant change in the resident s physical, mental or psychosocial status. A significant change includes deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications. C. A need to alter treatment significantly. A need to alter treatment significantly means a need to stop a form of treatment because of adverse consequences (such as an adverse drug reaction), or commence a new form of treatment to deal with a problem (for example, the use of any medical procedure, medication, or therapy that has not been used on the resident before). D. A decision to transfer or discharge the resident from the facility. 2. The nurse will notify the resident, resident s physician and the resident representative for non-immediate changes of condition on the shift the change occurs unless otherwise directed by the physician. 3. Document the notification and record any new orders in the resident s medical record. 4. Educate the resident and/or representative about the proposed plan to treat, manage or monitor the resident s	

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F 157	Continued From page 5	F 157	change in condition. 5. Educate the resident and/or resident representative about the risks and benefits of the proposed treatment change and provide an opportunity for the resident to make an informed choice of the treatment or alternative that they prefer. Communicate the resident s preference to the provider if it differs from the provider s proposed plan. 6. Update the resident s care plan, transcribe and implement the provider s orders. 7. Communicate the changes to the rest of the care team and inform the supervisor. 8. Communicate the changes to the staff on the oncoming shift by verbal report and the 24-hour communication sheet.	
F 282 SS=D	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CFR(s): 483.21(b)(3)(ii) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the plan of care related to transfers for 1 of 3 residents (R29) reviewed for accidents.	F 282	Plan of correction: The facility will utilize a resident summarized care plan checklist to ensure that all residents care plans are being followed. By utilizing these care plan	12/19/17

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F 282	Continued From page 6 Findings include: R29's significant change Minimum Data Set dated 9/12/17, indicated he was severely cognitively impaired, required extensive assistance from two staff for bed mobility, transfers and toileting, and was frequently incontinent of bladder. A Care Area Assessment dated 9/19/17, indicated a high risk for falls related to dementia, orthostatic hypotension and medication use. R29's care plan dated 10/5/17, identified a high risk for falls with actual falls. The care plan directed staff to transfer with assist of two staff with all transfers During an observation on 11/15/17, at 10:13 a.m., nursing assistant (NA)-C transferred R29 to the toilet. There was no second staff member nor was transfer belt used. R29 was assisted off the toilet using a transfer belt. While attempting to transfer R29 from his wheel chair to his bed, NA-C requested the help of a second staff member as R29 was unable to stand with assistance of one. After transferring him to the bed, NA-C applied a Tabs alarm to R29's shoulder and sock. There was a pressure alarm under him in bed, and a fall mat placed on the floor next to the bed. During an interview on 11/15/17, at 10:13 a.m. NA-C stated she transferred R29 to the toilet by herself without a transfer belt. She stated she uses two staff members when he is weak. NA-C stated she was supposed to use a transfer belt. During an interview on 11/15/17, at 1:46 p.m., the director of nursing (DON) stated R29 transferred with one staff and a gait belt, even though the care plan indicated two staff at all times. The	F 282	checklists, staff will be able to easily be up-to-date with resident care needs. The Director of Nursing or designee will conduct monthly audits reviewing residents care plans to the summarized care plan checklists. Results of audit finding will be reviewed at the quarterly QAPI meetings. These systematic changes will be discussed at the December 19, 2017 meeting. Plan of correction completion date is December 19, 2017.	

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F 282	Continued From page 7 DON stated she expected staff to follow the plan of care. A facility policy related to following the plan of care was requested but not received.	F 282		
F 314 SS=D	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(b)(1) (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide appropriate care to prevent pressure ulcers from developing for 1 of 2 residents (R28) who developed pressure ulcers while in the facility and who were observed for pressure ulcers and dressing changes and the facility failed to accurately assess and monitor pressure injury wounds for 1 of 2 residents (R28) who was identified having wounds.	F 314	Plan of correction: When pressure areas, skin injuries or other related skin issues are discovered, nursing assistants will immediately notify licensed staff. The facility will utilize a skin integrity worksheet for nursing assistants to fill out for all residents on their bath day. This skin integrity worksheet will be turned into licensed staff to review on a daily basis. This skin	12/19/17

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F 314	Continued From page 8 Findings include: R28 was observed 11/13/17, at 5:26 p.m. during a stand assist transfer with the mechanical stand and assisted by nursing assistant (NA)-A and NA-D. During the transfer, a purple area on the right buttock was observed, there was no dressing covering the area. R28 was lowered to the commode and said ouch, NA-D asked did your bottom hurt and R28 responded, "Yes." When R28 was lifted from the commode, NA-A wiped soft green stool across the purple area twice, then using toilet paper already soiled with feces, buffed in a circular motion the purple area three more times, staff removed one soiled glove, and did not wash their hands. There was a new area on the left buttock/hip area that was a raised red blister approximately 0.5 centimeters (cm) by 0.5 cm, with red fluid draining out the distal side and there was a small amount of blood on the outer left edge of the toilet seat. NA-A stated the wound nurse [registered nurse (RN)-A] wound be on duty tomorrow. R28 was then lowered to the wheelchair. On 11/13/17, at 7:20 p.m. the director of nursing (DON) was notified of the new wound on the left buttock/hip. R28's dressing change was observed on 11/15/17, at 1:21 p.m. RN-A washed her hands when entering the room, RN-A removed dirty dressings from the toe and heel wounds. RN-A then measured toe and heel wounds, cleaned the toe and heel wounds. RN-A then painted the toe and heel wounds with betadine (anti-septic solution), and redressed them, and applied Rooke boots (off-loading boots and designed to protect your limb, retain vital body heat, and allow for unrestricted circulation). RN-A moved to the	F 314	integrity worksheet will become part of the resident s medical record. Licensed staff will assess, document, and monitor on a regular basis until healed. The licensed nursed will notify the wound nurse of skin injury. The wound nurse will monitor at least weekly the condition of the skin injury and update physician and resident representative on progress. The wound nurse will document skin injury condition, notification of physician and resident representative on the Wound Integrity Log. The Director of Nursing will review the Wound Integrity Log each week to ensure compliance. Plan of correction completion date will be December 19, 2017.	

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right buttocks wound, cleansed them and left them open to air. RN-A then measured the new left hip-wound and the wound measured 0.2 cm x 0.2 cm covered with dry scab formation. Erythema surrounded the scab formation which measured 0.2 cm x 0.5 cm. prior to leaving the room RN-A, RN-A was interviewed about staff who were observed to wipe stool over the pressure area on the right buttock, RN-A stated she would expect the staff to wipe front to back and not over a pressure area.

R28 was admitted to the facility on 10/7/13, the Diagnosis Report dated 11/16/17, included Parkinson's Disease, diabetes mellitus, chronic obstructive pulmonary disease (COPD), and depressive disorder.

The diabetes care plan last revised 12/18/14, indicated "will have feet washed weekly with bath and inspected by licensed nurse." Staff were to monitor/document/report to R28's medical doctor (MD) as needed for signs and symptoms of infection to any open areas: redness, pain, health, swelling or pus formation.

A Physician Order dated 10/30/15, indicated R28 was to have weekly skin assessment, vitals and weight to chart in computer every day shift, every Thursday with bath. On 12/16/15, the Physician Order read, "Float heels when in bed."

The Minimum Data Set (MDS) dated 8/25/17, indicated R28 had moderate cognitive impairment, was mildly depressed, and required extensive assist of two persons for bed mobility and extensive assist of one person for transfers, toilet use, personal hygiene and dressing. R28 required staff to assist with activities of daily living

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F 314	Continued From page 10 due to poor balance, weakness, poor coordination secondary to Parkinson's Disease. R28 was at risk for pressure ulcer development related to impaired mobility, diabetes, Parkinson's, history of pressure areas, need for assist with turn and reposition, pain, did not currently have pressure ulcers. R28 was identified as being a moderate risk to develop pressure injury related to incontinence, limited sensory perception and mobility, ambulated occasionally, and problem with friction and shear. R28 required assist and reminders every two hours to reposition, can make small shift changes independently, but large shifts require staff assist. Reports some pain shooting six from zero to 10 scale, cannot stay in wheelchair to long. The MDS noted R28 had moderate cognitive impairment. R28's Temporary Care Plan for Skin Integrity dated 10/9/17, noted blackened areas and tips of right first and third toes with interventions of staff to monitor for signs and symptoms of infection, and monitor for pain discomfort. A Temporary Care Plan for Skin Integrity undated, indicated R28 at risk for skin integrity concerns and listed interventions of elevate heels off the bed with pillow. Weekly skin assessment was to completed by licensed staff, and heel protector boots were to be on at all times. A Progress Note dated 10/9/17, by DON indicated the MD saw R28 concerning right foot black circular areas on right great toe and right 3rd toe. The injury came from feet slipping on the mechanical lift stand and bumping feet into the stand while standing up. MD wrote progress notes to avoid repeated trauma. Staff would apply two to three roll up towels between the foot stand	F 314		

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and the base of the stand for protection. R28 was to wear gripper socks with toes cut out on the right foot and toes open to air and to cleanse with betadine and apply triple antibiotic ointment daily and follow up in one week.

Wound documentation and Physician Orders noted on 10/11/17, wound notes "compromised skin integrity hand written notes (no prior documentation was found). The right great toe pressure 0.5 cm x 0.5 cm, new and right third toe pressure 0.5 cm x .7 cm, new. The wound documentation did differentiate the type of ulcer which was pressure however, the documentation lacked evidence of the stage of the ulcer, the description of the ulcer's characteristics, if infection was present, assessment of pain, and the monitoring of the dressings and treatments, if effective or not.

On 10/16/17, the wound notes (new computer based form with typed notes, no body drawing) indicated the right great toe abrasion/pressure 0.5 cm x 0.5 cm, improved and right third toe abrasion /pressure 0.4 cm x 0.6 cm was new. The wound documentation did differentiate the type of ulcer which was pressure however, the documentation lacked evidence of the stage of the ulcer, the description of the ulcer's characteristics, if infection was present, assessment of pain, and the monitoring of the dressings and treatments, if effective or not.

A Progress Note on 10/23/17, by RN-D noted after R28's bath that morning, R28 had a 4 cm x 7 cm intact fluid filled blister on the right heel. Pressure relieving heel protector boots were on feet. Staff would float heels when in bed. The note lacked evidence of the type of ulcer whether

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it was pressure or non-pressure related and the stage of the ulcer.

An order dated 10/23/17, indicated float heels when in bed. Heel protector boots were to be applied at all times. An order dated 10/23/17, read, "Right heel every shift, remove heel protectors every shift and check right heel/blister for changes/signs of infection, check left heel for signs of breakdown."

A skin integrity concern care plan was added 10/23/17, with hand written note "intact blister right heel" weekly wound progress assessment/documentation by nurse, treatment as ordered, monitor for signs and symptoms of infection, treat infection as ordered, monitor for pain discomfort, pressure reduction devices, had hand written notes "heel protectors" notify physician/nurse practitioner and family designee if wound has not shown progress in two to four weeks or had declined. The Potential for Skin Integrity issues care plan was revised (hand written note dated 10/29/17) open area right buttock pressure area would heal within one month. The pressure ulcer on the right heel would heal within one month, stage 2 (partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister) was crossed out and unstageable (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar) was written in. The interventions added were "turn and reposition every hour, air mattress to bed, cushion in wheelchair, apply Bacitracin [topical antibiotic cream] and ABD [padded dressing approximately 5 inches by 9 inches] to protect

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heel, diabetic boots to be worn, elevate heels on pillow." A hand written and undated note was added to the care plan that stated: "Tips of 1st and 3rd toes, Deep Tissue Injury 10/9/17." The goal was the area would resolve without incident within two months. The interventions included diabetic boots and betadine (a topical antiseptic solution)/Bacitracin per MD orders.

On 10/24/17, at 12:01 a.m. a Progress Note by licensed practical nurse (LPN)-B indicated, the facility received a fax on R28's blister on the right heel. The MD noted the blister and dressing per nurse's orders with no changes to treatment at that time. At 6:23 a.m. a Progress Note indicated dressing changed on right heel which had blister that had drained onto ABD dressing area cleaned and betadine and Bacitracin applied new ABD dressing and diabetic boots reapplied, legs had lotion applied and the boots were reapplied. The documentation of the dressing change lacked evidence of the staging, if pain was present, and description of the surrounding tissue.

On 10/25/17, the wound note read, right great toe abrasion/pressure 0.7cm x 0.8 cm, decline right 3rd toe abrasion/pressure 0.7 cm x 1.0 cm, stable, the right heel 4.0 cm x 5.0 cm stable, and a new right buttock. The wound documentation did differentiate the type of ulcer which was pressure however, the documentation lacked evidence of the stage of the ulcer, the description of the ulcer's characteristics, if infection was present, assessment of pain, and the monitoring of the dressings and treatments, if effective or not.

On 10/28/17, at 3:07 p.m. RN-D charted R28's dressing to right heal changed at that time. The

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heal was blackened with areas of pink around wound edges. The area was cleansed with saline (salt solution), Bacitracin applied, and ABD placed over wound. No drainage or warmth were noted and the area presented with no signs or symptoms of infection. The dressing change documentation lacked evidence of staging of the wound.

A Physician Order dated 10/31/17, read, "Monitor open area on right buttock and apply Allevyn [wound dressing that supports healing] as needed."

On 11/1/17, the wound note noted, the right great toe abrasion/pressure 0.6 cm x 0.8 cm, improved, the right third toe abrasion/pressure 0.7 cm x 0.9 cm was stable, the right heel 2.5 cm x 6.0 cm was stable, and the right buttock, measured over the weekend as 1.0 cm x 0.6 cm was stable. The wound documentation did differentiate the type of ulcer which was pressure however, the documentation lacked evidence of the stage of the ulcer, the description of the ulcer's characteristics, if infection was present, assessment of pain, and the monitoring of the dressings and treatments, if effective or not.

On 11/8/17, the wound note read, the right great toe abrasion/pressure 0.5 cm x 0.8 cm, improved, the right third toe abrasion/pressure 0.7 cm x 0.4 cm was stable, the right heel 2.5 cm x 3.0 cm was stable, and the pressure purple area on right buttock, measured over the weekend, was 2.5 cm x 2.8 cm, decline. The wound documentation did differentiate the type of ulcer which was pressure however, the documentation lacked evidence of the stage of the ulcer, the description of the ulcer's characteristics, if infection was present,

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL-MOR MANOR	**96 THIRD STREET EAST MORGAN, MN 56266**

(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 314	Continued From page 15 assessment of pain, and the monitoring of the dressings and treatments, if effective or not. A Progress Note dated 11/9/17, by RN-C indicated the bath aide noted a black size area to R28's right first and third toe. The areas were not open and resident denied pain. The DON was aware. The first toe measured 0.5 cm by 0.5 cm. The third toe measured 0.7 cm x 0.5 cm. The nurse indicated the cause was the toes rubbing up against standing lift. The staff were educated to use care when using lift, and staff would switch residents socks from personal socks that are slightly tight to gripper socks, which are looser in the toes and increase grip on standing lift. R28's MD was notified. The nursing staff would continue to monitor area. The documentation lacked evidence of staging of the wounds. A Progress Note by LPN-B dated 11/13/17, at 11:38 p.m. indicated, the area on R28's left hip was open. The area was cleansed with normal saline and a Band-Aid was applied. The area was pink in color, open, and had no drainage. The area measured 1.6 cm x 1 cm. Nursing would continue to monitor until healed. The note lacked evidence of the type of ulcer whether it was pressure or non-pressure related and the stage of the ulcer. On 11/15/17, at 1:00 p.m. the wound assessment noted the following: the right great toe, non-tender, dark dry scab formation measured 0.7 cm x 0.9 cm. The right 3rd toe 0.6 x 0.6 cm and had a dark dry scab, non-tender scab formation measured 0.6 x 0.6 cm. The right heel, sloughed dry skin. There was decreased edema of heel area. The medial heel, superior dark dry scab measured 0.3 x 0.3 cm. The medial heel	F 314		

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F 314	Continued From page 16 inferior dark dry scab formation, non-tender measured 0.4 cm x 0.5 cm. Open area of heel measured 1.2 cm x 1.5 cm. margins are well defined. The wound bed covered with smooth granulation tissue. There was a scant amount of sero-sanguineous drainage on old dressings. The areas presented with no signs or symptoms of infection. R28 complained of discomfort with treatment of open area of heel. The left hip-wound measured 0.2 cm x 0.2 cm covered with dry scab formation. Erythema surrounded the scab formation which measured 0.2 cm x 0.5 cm. The wound documentation did differentiate the type of ulcer which was pressure and characteristics of the wound (s) however, the documentation lacked evidence of the stage of the ulcer, and the monitoring of the dressings and treatments, if effective or not. The East Resident Care Worksheet undated, directed the nursing assistants (NAs) to care for R28 with assist of one for transfers with EZ stand (mechanical stand assist device), two assist if tired or weak, toilet assist of one with EZ stand, and the night shift was to toilet at least once. R28 did not ambulate and staff were to turn and reposition every one hour. On 11/16/17, at 10:53 a.m. the DON, stated "would expect proper wound documentation and perineal care." Askills fair next week everyone has to test out on proper perineal care. Would expect to have proper hand hygiene during pressure ulcer dressing changes. A pressure ulcer policy and procedure was requested but not received.	F 314		
F 323	FREE OF ACCIDENT	F 323		12/19/17

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F 323 SS=D

Continued From page 17
HAZARDS/SUPERVISION/DEVICES
CFR(s): 483.25(d)(1)(2)(n)(1)-(3)

(d) Accidents.
The facility must ensure that -

(1) The resident environment remains as free from accident hazards as is possible; and

(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.

(1) Assess the resident for risk of entrapment from bed rails prior to installation.

(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.

(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to perform root cause analysis in an effort to reduce the risk for falls for 1 of 3 residents (R29) reviewed for accidents.

Findings include:

R29's significant change Minimum Data Set dated 9/12/17, indicated he was severely

F 323

Plan of correction:
The facility will implement the Root Cause Analysis process (RCA) upon receipt of all fall incident reports. The Director of Nursing or designee will review the fall incident report and conduct the RCA to identify the key factors that if changed would likely prevent the undesirable outcome. The interdisciplinary team will

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F 323	Continued From page 18 cognitively impaired, required extensive assistance from two staff for bed mobility, transfers and toileting, and was frequently incontinent of bladder. A Care Area Assessment dated 9/19/17, indicated a high risk for falls related to dementia, orthostatic hypotension and medication use. R29's care plan dated 10/5/17, identified a high risk for falls with actual falls and indicated self-transfer attempts. The care plan directed staff to bring R29 to an activity after supper, transfer with assist of two staff with all transfers and review information on past falls to determine cause of falls. The care plan identified use of a floor mat and tabs alarms (The Pull-Tab Alarm features a pull-string that attaches magnetically to the alarm with garment clip to the resident. When the resident attempts to rise out of their chair or bed the pull-string magnet is pulled away from the alarm that caused the alarm to sound, alerting the caregiver) to the outside of his bathroom door, attached to lower pant leg and shoulder area. During an observation on 11/15/17, from 8:07 a.m. to 10:12 a.m. R29 was wheeling himself independently around the facility. At 8:07 a.m. he wheeled himself away from his table in the dining room and over to a window. From 8:09 a.m. to 9:24 a.m. he propelled himself around the dining room. At 9:24 a.m., R29 wheeled himself past the nurse's station and down the hall toward the west end of the facility. At 9:26 a.m., a staff member directed him towards his room. At 9:30 a.m., staff pushed R29 in his wheel chair, back to the dining room and placed him in front of the television. An activity was occurring in the chapel at this time. At 9:40 a.m., he propelled himself into the business office by the front entrance of the facility. At 9:46 a.m., he wheeled himself out of the office and	F 323	review weekly the facts in each case to identify any human, equipment, environmental, information, and communication, or possible policy, procedure and practice factors to prevent further undesired outcomes. On a quarterly basis, the Director of Nursing will compile the incident data to be reviewed at our QAPI meeting. Plan of correction completion date will be December 19, 2017.	

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across the dining room. At 9:50 a.m., R29 was again propelling himself down the hall toward the west unit of the facility.

During an observation on 11/15/17, at 10:13 a.m., nursing assistant (NA)-C transferred R29 to the toilet. There was no second staff member nor was transfer belt used. R29 was assisted off the toilet using a transfer belt. While attempting to transfer R29 from his wheel chair to his bed, NA-C requested the help of a second staff member as R29 was unable to stand with assistance of one. After transferring him to the bed, NA-C applied a tabs alarm to R29's shoulder and sock. There was a pressure alarm under him in bed, and a fall mat placed on the floor next to the bed.

A review of facility Fall Incident Reports dated 1/30/17 through 11/7/17, identified the following:

- 1/30/17, at 8:00 p.m. R29 fell in his room. He stated he was standing up next to the bed. Intervention included 10 minute checks when restless, after supper if tired put to bed and if restless, take to activity and toilet every two hours. A fall investigation worksheet identified use of a tabs alarm and identified restlessness and agitation as contributing factor.

- 2/26/17, at 11:30 p.m. R29 found on the floor in his room. tabs alarm had been removed "(resident removes these") and bed alarm did not sound. Intervention to remind him that tabss alarms are for his own safety and to leave them clipped to his clothes. Self transfers and removal of alarms were identified as contributing to falls.

- 3/18/17, at 8:00 p.m. R29 was found lying on his

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back in a conference room on another unit. He had been wandering throughout the facility and attempting to go outside, He had previously attempted to exit the facility through two separate doorways. He sustained scratches, a cut on his left arm, bump on the back of his head and a bruise on his back. Interventions included one to one's, take for a walk, offer snack and bed. A fall investigation worksheet identified increased anxiety and wanting to go outside as contributing to fall.

- 7/14/17, at 8:20 p.m. R29 fell "when trying to shut off motor on w/c [wheelchair] (tabs alarm pressure pad)." stated wheel chair moved on him. Found on dining room floor, bumped his head. Interventions included anti-rollbacks on wheel chair, continue 30 minute checks. A fall Investigation Worksheet did not include a fall analysis.

A Gil Mor Manor Progress Note dated 9/22/17, indicated at 9:00 a.m., R29 walked out of bed and into the hallway. Removed alarms himself.

- 9/23/17, at 10:25 p.m. R29 had been in bed and unhooked his alarm. He tried to walk to his walker and fell. He sustained two small abrasions on his left buttock. Interventions to attach alarms to head and foot of bed and toilet every two hours. A Fall Investigation Worksheet indicated he was confused and thought he had to meet someone and contributing to the fall. A facility form titled New Intervention For Fall or Incident dated 9/24/17, indicated staff were not following the plan of care related to the alarms.

- 9/29/17, at 8:10 a.m., R29 was found sitting on the floor by his bed. Stated he was ready to get

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up. Tabs alarm #1 was hooked to pillow case, 2nd was hooked on blanket, bed sensor was pushed to the side of bed. Intervention to re-enforce to him that tabs need to stay on for his safety and monitor frequently. A Fall Investigation Worksheet identified him removing his alarms as a contributing factor to his fall.

A Gil Mor Manor Progress Note dated 10/5/17, indicated R29 was in bed at 8:30 p.m. and by 10:00 p.m., had unhooked his alarm and was seated on the edge of his bed.

A Gil Mor Manor Progress Noted dated 10/10/17, indicated R29 transferred himself from the bed to the wheel chair. He had unhooked his shoulder alarm.

- 10/22/17, at 7:05 p.m. staff were called to the activity room. R29 was seated on the floor with alarm sounding. He reported hitting his head and stated he was getting ready for bed. Intervention included put R29 to bed if noted to be tired or lethargic. There was no Post Fall Investigation report included.

A Gil Mor Manor Progress Note dated 11/1/17, indicated R29 was sitting up on the edge of his bed with shoulder and sock alarms un-hooked.

- 11/7/17, at 6:45 a.m., R29 was found on the floor beside his bed. alarms did not sound and sensor was up against the wall. Interventions included make sure alarm was attached to clothing where he cannot reach to unhook and more frequent checks in bed. There was no Post Fall Investigation report included.

During an interview on 11/15/17, at 10:13 a.m.

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NA-C stated she transferred R29 to the toilet by herself without a transfer belt. She stated she used two staff members when he was weak. NA-C stated she was supposed to use a transfer belt. At 10:23 a.m., NA-C stated R29 tried to toilet himself and stated, "I guess the alarms are an easy intervention." She stated he was able to remove the tabs alarms.

During an interview on 11/15/17, at 1:09 p.m., licensed practical nurse (LPN)-A stated R29 was admitted with a diagnosis of Parkinson's exacerbation and got progressively worse. She stated a few months prior he was having spells where he would pass out. LPN-A stated R29 removed his alarms and hooked them to sheets and pillows and stated he could move the pressure pad alarm so it would not activate. She stated the staff performed frequent checks on him. She stated they have tried to move the alarms to different sites, hooked an alarm to his bathroom door and tried involving him in activities. She stated she felt the alarms made R29 stop if he was attempting to self-transfer and stated they were mainly kept on because it took him a while to get up. She stated staff were not consistently monitoring his blood pressure unless he was symptomatic.

During an interview on 11/15/17, at 1:46 p.m., the director of nursing (DON) stated falls were discussed weekly at an interdisciplinary team meeting. She stated R29 tried to crawl out of bed or go to the bathroom by himself. She stated they were trying to discontinue alarms and provide more checks and more toileting and stated if he was tired they put him to bed. The DON stated the determined if staff took him to the bathroom every two hours at night it helped to decrease his

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F 323	Continued From page 23 falls but stated they did not like to wake him up because he had a hard time falling asleep. She stated R29 did not understand to use his call light. She stated she was not sure what was different during the months R29 was not falling. She further stated R29 transferred with one staff and a gait belt, even though the care plan indicated two staff at all times. The DON stated she expected staff to follow the plan of care. A facility policy related to fall assessment and interventions was requested but not received.	F 323		
F 334 SS=D	INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS CFR(s): 483.80(d)(1)(2) (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following:	F 334		12/19/17

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(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and

(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-

(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;

(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;

(iii) The resident or the resident's representative has the opportunity to refuse immunization; and

(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:

(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and

(B) That the resident either received the

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F 334	Continued From page 25 pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their facility policy related to pneumococcal conjugate vaccine (PCV13) for 2 of 5 residents (R12, R29) whose vaccination histories were reviewed. Findings include: Center for Disease Control and Prevention indicated, "Adults 65 years of age or older who have not previously received PCV13 and who have previously received one or more doses of PPSV23 [pneumococcal polysaccharide vaccine 23] should receive a dose of PCV13. The dose of PCV13 should be given at least 1 year after receipt of the most recent PPSV23 dose." R12's Gil Mor Manor Admission Record indicates she admitted to the facility on 12/8/14. A review of a Minnesota Immunization Information Connection (MIIC) form indicated R12 received the PPSV23 immunization on 9/7/11 and indicated she was overdue for the PCV13 vaccination. A hand written note on the bottom of the form dated 9/14/17, indicated: talked to R12 about getting vaccine. Will need to get in clinic. A second handwritten note dated 11/15/17 indicated: R12 to get vaccine in November. R29's Gil Mor Manor Admission Record indicated he admitted to the facility on 6/24/15. A review of a MIIC form indicated R29 received the PPSV23 immunizations on 11/12/2007 and 2/1/2010. The Form identified the PCV-13 vaccination was	F 334	Plan of correction: The Director of Nursing or designee will review immunization records via MIIC for all new admissions as well as current residents, fax the physician to determine eligibility to receive pneumococcal vaccines. If resident is eligible, licensed nurse will provide education to the resident and/or resident representative regarding the benefits and potential side effects of the immunization. If the resident chooses to be immunized, after education is provided, licensed nurse will give the resident and/or resident representative a choice of receiving the immunization in-house, at the primary physician s office or another location of their choice. If resident or resident representative chooses to receive the immunization at the facility, the vaccine will be ordered and given at the facility. Every three months with the resident care plan review, the Director of Nursing or designee will review MIIC to ensure immunizations are up-to-date to ensure compliance. If the resident initially refused the immunization, facility will again provide education and offer the vaccination. On a quarterly basis, the Director of Nursing or designee will report the findings of the review to the QAPI meetings. Plan of correction completion date will be December 19, 2017.	

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F 334	Continued From page 26 overdue. A note, handwritten on the bottom of the form, dated 11/15/17, indicated: called Springfield clinic on February 2017, note was made to physician to give client Prevnar 13 at visit. The immunizations were not given at that visit. Wife was called and stated do not give vaccine. During an interview on 11/15/17, at 12:10 p.m., the director of nursing (DON) stated the facility does not offer the vaccine to residents due to the cost. She stated they have to go to the clinic. At 12:24 p.m. the DON stated she would call the clinic to see if R29 had received the vaccine. She further stated she spoke with R12 and stated R12 would get the vaccine at a visit scheduled in November. At 1:06 p.m., the DON stated R29 had not received the vaccine. During a subsequent interview on 11/16/17, at 8:37 a.m., the DON stated she was responsible for ensuring the vaccinations were up to date. She stated R29's wife didn't want to pay for it due to cost. A facility policy titled Morgan Memorial Foundation, Inc. d.b.a. Gil Mor Manor and Gil Mor Haven dated 10/25/16, indicated the facilities goal is to establish and maintain policies and procedures for the prevention and control of influenza and pneumonia that are based on CDC recommendations. The policy directed the facility to offer Prevnar 13 or pneumococcal vaccine after review of the residents records.	F 334		
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program.	F 441		12/19/17

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	245594	A. BUILDING ______ B. WING ______	C 11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL-MOR MANOR	**96 THIRD STREET EAST MORGAN, MN 56266**

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F 441	Continued From page 27	F 441		

The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the

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F 441	Continued From page 28 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper wound care, and hand and glove hygiene was implemented to prevent the spread of potential infection for 2 of 3 residents (R28, R30) who were observed for cares. Findings include: R28 was observed 11/13/17, at 5:26 p.m. during a stand assist transfer with the mechanical stand and assisted by nursing assistant (NA)-A and NA-D. During the transfer, a purple area on the right buttock was observed, there was no	F 441	Plan of correction: The facility provided hand hygiene education training, skills demonstration and test out for all staff throughout the month of November, the completion date for this training was November 30, 2017. Additional education, training, skills demonstrations and test out was provided at our Annual Skills Fair held on November 21 and 22, 2017. The following education, training and skills demonstration areas were as follows; perineal care, bed bath, catheter care, vital signs, personal protective equipment	

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F 441	Continued From page 29 dressing covering the area. R28 was lowered to the commode and said ouch, NA-D asked did your bottom hurt and R28 responded, "Yes." When R28 was lifted from the commode, NA-A wiped soft green stool across the purple area twice, then using toilet paper already soiled with feces, buffed in a circular motion the purple area three more times, staff removed the soiled glove, and did not wash their hands. On 11/15/17, at 1:21 p.m. RN-A was observed doing pressure ulcer dressing change for R28. RN-A was not aware of the incident on 11/13/17, when resident said ouch after being transferred to the commode on a stand assist. RN-A washed her hands when entering the room, RN-A removed dirty dressings from the toe and heel wounds, changed her gloves, but did not wash her hands. RN-A then measured toe and heel wounds, cleaned the toe and heel wounds, changed her gloves, but did not wash her hands. RN-A then painted the toe and heel wounds with betadine, and redressed them, and applied Rooke boots with the same gloves on. RN-A then changed her gloves but did not wash her hands. RN-A moved to the right buttocks wound, cleaned them and left them open to air. RN-A then measured the new left hip-wound measured 0.2 x 0.2 cm covered with dry scab formation. Erythema surrounding scab formation measures 0.2 cm x 0.5 cm. When leaving the room, RN-A removed the soiled gloves and then washed her hands. When informed that staff had been observed wiping stool over the pressure area on the right buttock, RN-A stated she would expect the staff to wipe front to back and not over a pressure area.	F 441	(gown, gloves, mask and goggles), emptying Foley collection bags, measuring urine output, safe patient transfers, safe patient ambulation, applying ted hose. The facility licensed staff will receive additional wound care education and training from Ann Marie Equio, a wound care specialist from American Medical Technologies on December 19, 2017. The Director of Nursing or designee will perform audits on a quarterly basis and report finding to the quarterly QAPI meetings for review to ensure compliance with infection control quidelines. Plan of correction completion date will be December 19, 2017.	

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F 441	Continued From page 30 R30 was observed on 11/15/17, at 1:57 p.m. RN-A was observed doing pressure ulcer dressing change for R30. RN-A washed her hands when entering the room, donned gloves and cleaned off bedside table with disinfectant wipe, changed the soiled gloves but did not wash hands. RN-A used a pair of orange handled scissors to cut off old dressings and then placed scissors back into supply bucket without being disinfected. After removing old dressing with drainage, RN-A removed her gloves, and did not wash her hands. RN-A then reached into the Kerlix package to retrieve dressings to cleanse R30's toes. RN-A did not change gloves or wash hands after cleaning between the toes. RN-A then removed more dressings from the package in the supply bucket to dry toes using the same soiled gloves. RN-A then cleansed and measured the metatarsal wound, changed the soiled gloves, but did not wash hands. RN-A prepared the dressing to re-dress the wound, painted wound with betadine and put their hands back into supply bucket to get scissors to cut dressing. RN-A used the same soiled orange handled scissors that was used to cut off the soiled dressing from R30's toes. Xeroform (a sterile petrolatum dressing used for exudative wounds) was in a large piece in a bag that had been opened before, the [sterile] dressing was accessed without changing gloves or washing hands, and a piece was cut off with used and unclean scissors, this piece of Xeroform dressing was then placed into the wound bed of the metatarsal wound, then covered with ABD pad and Kerlix wrap. RN-A used orange handled scissors to cut Kerlix, then covered with Coban around foot and once around ankle to anchor it. Coban cut with orange scissors. supplies put back into box. Rooke boot was reapplied without changing gloves or	F 441		

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F 441	Continued From page 31 washing hands. RN-A failed to follow the standard of care for hand hygiene and pressure ulcer wound care during dressing changes. When interviewed RN-A stated she washed her hands when she entered and room and when she finished, but did not wash her hands between times, unless there was a lot of drainage from the wound. On 11/16/17, at 10:53 a.m. DON, stated "would expect proper perineal cares and hand hygiene." A skills fair was scheduled next week and everyone had to test out on proper perineal care. A hand hygiene policy was requested but not received.	F 441		

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

F5594027

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**11/15/2017**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS FORM-2567 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on Novemebr 15, 2017. At the time of this survey, Gil-Mor Manor was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 12/08/2017

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Gil-Mor Manor was constructed as follows: The original building was constructed in 1963, is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 1989 building addition is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction.	K 000		
K 133 SS=F	Multiple Occupancies - Construction Type CFR(s): NFPA 101 Multiple Occupancies - Construction Type Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the	K 133		11/15/17

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K 133	Continued From page 2 construction type is determined as follows: * The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1 * The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to maintain a 2-hour separation is provided in accordance with 8.2.1.3. The deficient practice could affect 30 out of 30 residents. Multiple Occupancies - Construction Type Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: * The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1 * The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3 FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:00 PM	K 133	Plan of correction: The maintenance technician removed the kick down device and repaired the latching mechanism on the 2-hour fire separation door located between Gil-Mor Manor and the Medical Clinic on November 15, 2017. Plan of correction completion date was November 15, 2017.	

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K 133	Continued From page 3 on 11/15/2017, observation revealed the door in the 2 hour fire separation wall between Gil-Mor Manor and the Medical Clinic failed to close and positively latch into the door frame and a kick down device was observed on the door. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 133		