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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: IMJV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00649

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245383**

2.STATE VENDOR OR MEDICAID NO.
(L2) **633442000**

3. NAME AND ADDRESS OF FACILITY
(L3) **OWATONNA CARE CENTER**
(L4) **201 SOUTHWEST 18TH STREET**
(L5) **OWATONNA, MN** (L6) **55060**

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) **01/01/2011**

6. DATE OF SURVEY **04/26/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **03** (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 **55** (L18)

13.Total Certified Beds **55** (L17)

10.THE FACILITY IS CERTIFIED AS:

X 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	IID
43	12			
(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):

On April 16, 2013 and on April 26, 2013, the Departments of Health and Public Safety completed Post Certification Revisits (PCR) and verified correction of the deficiencies issued pursuant to the March 1, 2013 standard survey, effective April 10, 2013. Refer to the CMS 2567b forms for both health and life safety code.

Effective April 10, 2013, the facility is certified for 55 skilled nursing facility beds.

17. SURVEYOR SIGNATURE Date :
Robin Lewis, HFE NEII 05/07/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 05/22/2013 (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
12/01/1986
(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.
00320
(L31)

30. REMARKS
Posted 5/31/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/05/2013
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5383

May 22, 2013

Ms. Brenda Schrupp, Administrator
Owatonna Care Center
201 Southwest 18th Street
Owatonna, Minnesota 55060

Dear Ms. Schrupp:

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 10, 2013 the above facility is certified for:

43	Skilled Nursing Facility Beds
18	Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of 43 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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

May 7, 2013

Ms. Brenda Schrupp, Administrator
Owatonna Care Center
201 Southwest 18th Street
Owatonna, Minnesota 55060

RE: Project Number S5383025

Dear Ms. Schrupp:

On March 18, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 1, 2013. 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 16, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on April 26, 2013 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 March 1, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 10, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 1, 2013, effective April 10, 2013 and therefore remedies outlined in our letter to you dated March 18, 2013, 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 related to this letter.

Sincerely,

Mark Meath

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5383r13.rtf

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245383	A. Building B. Wing	4/16/2013

Name of Facility	Street Address, City, State, Zip Code
OWATONNA CARE CENTER	201 SOUTHWEST 18TH STREET OWATONNA, MN 55060

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 **F0156** Reg. # **483.10(b)(5) - (10), 483.10(b)(1)** LSC	Correction Completed **04/10/2013**	ID Prefix **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	Correction Completed **04/10/2013**	ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **04/10/2013**
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **04/10/2013**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **04/10/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **04/10/2013**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **04/10/2013**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **04/10/2013**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **04/10/2013**
ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **04/10/2013**	ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **04/10/2013**	ID Prefix **F0365** Reg. # **483.35(d)(3)** LSC	Correction Completed **04/10/2013**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **04/10/2013**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **04/10/2013**	ID Prefix **F0456** Reg. # **483.70(c)(2)** LSC	Correction Completed **04/10/2013**

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/GPN	05/07/2013	30238	04/16/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 3/1/2013

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245383	A. Building B. Wing **01 - MAIN BUILDING 01**	4/26/2013

Name of Facility	Street Address, City, State, Zip Code
OWATONNA CARE CENTER	201 SOUTHWEST 18TH STREET OWATONNA, MN 55060

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 Reg. # **NFPA 101** LSC K0011	Correction Completed **04/10/2013**	ID Prefix Reg. # **NFPA 101** LSC K0029	Correction Completed **04/10/2013**	ID Prefix Reg. # **NFPA 101** LSC K0054	Correction Completed **04/10/2013**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/PS	05/07/2013	25822	04/26/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 2/28/2013		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245383	02 - 1992 ADDITION	4/26/2013

Name of Facility	Street Address, City, State, Zip Code
OWATONNA CARE CENTER	201 SOUTHWEST 18TH STREET OWATONNA, MN 55060

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0011	04/10/2013	ID Prefix Reg. # NFPA 101 LSC K0054	04/10/2013	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	MM/PS	05/07/2013	25822	04/26/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 2/28/2013

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: IMJV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00649

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245383**

2.STATE VENDOR OR MEDICAID NO.
(L2) **633442000**

3. NAME AND ADDRESS OF FACILITY
(L3) **OWATONNA CARE CENTER**
(L4) **201 SOUTHWEST 18TH STREET**
(L5) **OWATONNA, MN** (L6) **55060**

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) **01/01/2011**

6. DATE OF SURVEY **03/01/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **03** (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 **55** (L18)

13.Total Certified Beds **55** (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	IID
43	12			
(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 March 1, 2013 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 :
Robin Lewis, HFE NEII — 04/02/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Program Specialist — 04/05/2013 (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
12/01/1986
(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.
00320
(L31)

30. REMARKS
Posted 04/05/13 CO. IMJV

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 # 7011 2000 0002 5148 8397

March 18, 2013

Ms. Brenda Schrupp, Administrator
Owatonna Care Center
201 Southwest 18th Street
Owatonna, Minnesota 55060

RE: Project Number S5383025

Dear Ms. Schrupp:

On March 1, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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:

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506

Telephone: (507) 206-2731
Fax: (507) 206-2711

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 April 10, 2013, 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 April 10, 2013 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 June 1, 2013 (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 September 1, 2013 (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:

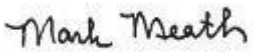
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions related to this letter.

Sincerely,



Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5383s13.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245383	A. BUILDING _____ B. WING _____	03/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWATONNA CARE CENTER	201 SOUTHWEST 18TH STREET OWATONNA, MN 55060

(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	This plan of correction is submitted as required under Federal and State laws. The submission of this Plan of Correction does not constitute an admission on the part of Owatonna Care Center as to the accuracy of the surveyors' findings or the conclusions drawn there from. The Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Facility's policies and policies and procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on this basis. The Facility submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Facility or any employee, agent, officer, director, attorney, or shareholder of the Facility or affiliated companies.	
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 156 04-01-13 JPM		

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

Barb L — Administrator — 3/28/13

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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F 156	Continued From page 1 inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and	F 156	F156 R64 discharged from the facility on 1/11/13. R67 discharged from the facility on 2/1/13. Policy regarding Demand Billings will be reviewed and updated by Administrator or designee. All department heads responsible for issuing denial notices will be educated on policy by Administrator or designee. Re-occurrence will be prevented by the Administrator or designee completing the following audits: 1. 3 Audits will be randomly completed per week to ensure denial notices were issued properly. All information will be brought to QA by Administrator to discuss findings and need for further auditing. Date of completion: April 10, 2013	

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F 156	Continued From page 2 misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to provide the appropriate liability and appeals notice for 2 of 3 residents (R64, R67) reviewed who received Medicare services. Findings include: R64's medical record review	F 156		

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F 156	Continued From page 3 revealed the resident was admitted to the facility on 12/17/12 and was discharged home on 1/11/13. R64 had not received form CMS 10123 (notice of non-Medicare coverage), also known as the "generic notice." R67's medical record review revealed the resident was admitted to the facility on 1/8/13, and was discharged home on 2/1/13. R67 had also not received form CMS 10123. An interview was conducted on 2/26/13, at 2:09 p.m. with a registered nurse (RN)-A, who verified R64 and R67 had been discharged home, so had not been provided the Medicare denial form. The administrator verified on 2/26/13, at 2:18 p.m. that when residents were discharged home, they had not been issuing Medicare denial forms.	F 156		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.	F 164		

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F 164	Continued From page 4 The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure confidentiality of medical information for 1 of 40 residents (R8) residing in the facility. Findings include: R8's confidential medical information could be overheard on 2/27/13, at 12:53 p.m.while R8 and facility staff were at a nursing station and busy hallway. R8 was asking about appointments and other medical information about herself. The medical records (MR) staff person was interviewed regarding the conversation on 2/27/13, at 1:29 p.m. The MR confirmed she had a conversation with R8 at the nurses' station, but said she did not offer to take the resident to a private location as she was looking at R8's chart to verify when there was to be follow-up with the doctor. MR verified the resident and the resident's medical record could have been taken to a private location to ensure audible privacy of R8's medical information.	F 164	F164 MR Staff Person educated on confidentiality of medical information. Policy regarding Resident Rights will be revlewed and updated by Administrator or designee. All staff will be educated on policy by Administrator or designee. Re-occurrence will be prevented by the Administrator or designee completing the following audits: 1. 5 Audits will be randomly completed per week to ensure communication in public areas/nurse's station protects resident's confidential medical information. All information will be brought to QA by Administrator to discuss findings and need for further auditing. Date of completion: April 10, 2013	

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F 164	Continued From page 5 On 3/1/13, at 7:35 a.m. the administrator stated expectations were for conversations with or about a resident were conducted in private or staff would at least be expected to suggest the conversation be in private to protect the residents' medical information. A facility policy titled Resident Rights dated 3/1/13, read "Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to...Privacy and confidentiality."	F 164		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop a system for ensuring routine maintenance repair and housekeeping services were offered in multiple resident rooms and common areas. This had the potential to effect 40 of 40 residents residing in the facility. Finds include: During initial tour on 2/25/13, at 6:15 p.m. on units 100, 200, and 300 hallway walls, baseboards and doors were in disrepair and unsanitary. At 6:40 p.m. a hand washing sink located on the 300 hallway was visibly soiled in the basin, the faucet and handles. A garbage can located below the sink was overflowing with	F 253	F253 The facility is in the middle of a re-model. The Facility Re-Model Schedule Owatonna was revised to include the following updates throughout 2013: • 100/200/300 removal of wall paper, fixing gouges and nail holes, painting the walls, doors, door frames, and replacing wall base. Hand washing sink down the 300 hallway was cleaned and the garbage was emptied. Chips in 300 wing day/activity room were cleaned up.	

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F 253	Continued From page 6 soiled napkins and the attached cover did not close fully. There were potato chips spilled under a table in the 300 wing day/activity room which was noted on the day of entering the facility 2/25/13 and still present on the day of exit 3/1/13. The administrator was interviewed at 6:45 p.m. and observed the concern. She said the expectation was garbage removal and sink sanitation daily and as needed. She was also aware of the multiple areas in the facility with wallpaper/walls in poor repair, and said they had begun the process of making the repairs, but did not have a written plan. The administrator would provide the surveyor a list of what repairs had been completed as well as a plan of upcoming repairs. On 2/26/13, at 8:55 a.m. the Facility Re-Model Schedule Owatonna list was provided by the maintenance/housekeeping director (MHD), and the MHD said he had just written the plan that morning. During observation on 2/26/13, at 8:52 a.m. resident room 313 was observed to have two TV stands stacked on top of each other with a television located on the top. The tables were easily moved using one hand. The MHD was notified and immediately removed the top table. MHD stated, "I guess it could fall easily." On 2/28/13, at 7:41 a.m. an environmental tour of the facility was conducted with the administrator, assistant administrator, and MHD. During the tour the following observations were noted: The physical therapy room had a closet door on	F 253	The 2 tv stands stacked in 313 were immediately removed upon discovery. The closet door in the therapy room was removed and the supplies were re-arranged. The call light covers were tightened in 107 and 209. 203 and 206 were re-painted. The bathroom doors and door frames were re-painted in 301 and 303. The ceiling tiles were replaced and the bathroom doors were re-painted in 302 and 304. The headboard in 313 was fixed so it securely attaches to the bed. The furniture in this room was dusted. 311 was re-painted and the wall repaired.	

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F 253	Continued From page 7 the north wall that had detached from the frame at the top of the door. The top of the door was observed to hang approximately six inches out toward the center of the room. Resident rooms 107 and 209 had loose call light covers. Resident room 203 had scuff marks on the wall by a recliner chair. Resident room 206 walls were in disrepair around the bathroom door and near the bed. Resident rooms 301 and 303 had chips and scrapes in the paint on the lower section of the doors and door frames inside the bathroom. Resident rooms 302 and 304 had bulging, stained ceiling tiles in the bathroom and chips and scrapes in the paint on the lower section of the bathroom doors. Resident room 313 had a headboard that was not attached securely to the bed. Resident furniture had a thick layer of dust. Resident room 311 had multiple areas of chips and scrapes on the walls including a cracked/dented area above bed approximately six inches in diameter. Resident rooms 315 and 318 were in disarray, and had visible dust on resident furniture surfaces. Hallway walls in the 100, 200 and and 300 wings had decorative boarder wallpaper that was	F 253	315 and 318 were cleaned and organized as the residents allowed. The mold on the floor in the 300 wing soiled utility room was cleaned. The door kick plate was cleaned. The cloth chair in the hallway was cleaned. The sink and air conditioner in the laundry room were both cleaned. Policy regarding Cleaning and Disinfection of Environmental Surfaces, Maintenance Service, and Cleaning/Repairing Carpeting and Cloth Furnishings will be reviewed and updated by the Maintenance Director or designee. New system put in place for ensuring routine maintenance repairs are communicated and completed, as well as a new system for housekeeping services. All staff will be educated on policies by Administrator or designee.	

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F 253	Continued From page 8 missing, peeling along the seams. Entry doors and door frames had scrapes on the finish down to the wood and scared off paint on the door frame. Hallway walls in the 200 and 300 wings had multiple areas of chipped paint, gouges and nail holes. The baseboards had a buildup of dark dirt fixed to it, around the perimeter of the floor all the way around the base. The edges and corners of walls were visibly soiled. The 300 hall soiled utility room utilized by staff to clean soiled clothing and linens had mold around the base to the floor, the door kick plate was soiled. A cloth chair in the hallway had soiled areas on the seat. The laundry room had a hand washing sink used by staff was visibly soiled. The air conditioner located directly above a counter used to fold resident clean clothing was covered with a thick layer of lint and dust on the front surface. The administrator and MHD observed the findings with the surveyor. The administrator was interviewed on 2/28/13, at 8:25 a.m. and stated she was aware of the concerns and had been in the process of making the repairs. She stated, "It's an old building, but it could be clean." The administrator and MHD confirmed the facility did not have a written plan for needed repairs prior to the survey. The MHD said a grievance was made by a resident regarding housekeeping at one time, and an investigation was completed. When asked whether an overall audit of housekeeping was	F 253	Re-occurrence will be prevented by the Administrator or designee completing the following audits: 1. 5 Resident rooms will be randomly audited per week to ensure they are cleaned properly. 2. 5 Common areas will be randomly audited per week to ensure they are cleaned properly. 3. 5 Resident rooms will be randomly audited per week to ensure they are in good repair. 4. The Maintenance log will be audited weekly to ensure timely follow-up is completed on concerns. All information will be brought to QA by Maintenance Director to discuss findings and need for further auditing. Date of completion: April 10, 2013	

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F 253	Continued From page 9 completed, the MHD stated, "I did take a peek." Cleaning and Disinfection of Environment Surfaces policy dated 2/28/13, directed staff to clean housekeeping surfaces on a regular basis, when spills occur, and when surfaces were visible soiled. Horizontal surfaces would be wet-dusted regularly. Maintenance Service policy dated 2/28/13, indicated the maintenance department was responsible for maintaining the building, grounds and equipment in a safe and operable manor at all times. The maintenance director was responsible for developing and maintaining a schedule of maintenance service to assure that the building, grounds and equipment were maintained in a safe and operable manner.	F 253		
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 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	F 279		

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F 279	Continued From page 10 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 plan of care for 1 of 4 residents (R68) reviewed for nutrition. Findings include: R68 was prescribed a therapeutic diet, however, lacked development of a care plan for nutritional needs. The resident was admitted to the facility in 1/13, however, the care plan reviewed on 3/1/13 lacked nutritional information to address the resident's individual needs. A Dietary Profile & Risk Assessment dated 2/1/13, revealed R68 received a therapeutic diet of 2 gram sodium, cardiac diet. It was also noted the resident had experienced a significant weight loss. The registered dietitian was to request diet liberalization from the attending physician. On 3/1/13, at 9:47 a.m. the director of nursing (DON) reviewed R68's care plan and verified there was not a nutritional care plan developed, but should have been completed within 14 days of the resident's admission. A policy, Care Plans--Comprehensive dated 1/10/12, read "The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment (MDS) [Minimum Data Set].	F 279	F279 A dietary care plan was completed for R68 on 3/1/13. Policy regarding Care Plans – Comprehensive will be revlewed and updated by Director of Nursing or designee. All staff responsible for care planning will be educated on policy by Director of Nursing or designee. Re-occurrence will be prevented by the Administrator or designee completing the following audits: 1. Whole house audit will be completed to ensure all residents have a comprehensive dietary care plan. 2. All new admissions will be audited to ensure they have a comprehensive.dietary care plan. All information will be brought to QA by Administrator to discuss findings and need for further auditing. Date of completion: April 10, 2013	
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO	F 280		

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	245383	A. BUILDING _____ B. WING _____	03/01/2013

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F 280 SS=D	Continued From page 11 PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to revise a plan of care for 1 of 2 residents (R53) reviewed for dental care. Findings include: R53's care plan did not address the resident's dentures and relevant oral care. On 2/26/13, at 9:54 a.m. R53 was observed and was not wearing dentures. The resident explained that she had been trying to adjust to new dentures for about a month, and was not	F 280	F280 R53 discharged from facility on 3/20/13. Policy regarding Care Plans – Comprehensive will be reviewed and updated by Director of Nursing or designee. All staff responsible for care planning will be educated on policy by Director of Nursing or designee. Re-occurrence will be prevented by the Director of Nursing or designee completing the following audits: 1. All current residents will have a new oral assessment completed. 2. Whole house audit will be completed to ensure all resident's oral assessment matches their care plan. 3. All new admissions will be reviewed to ensure the oral assessment matches the care plan. All information will be brought to QA by Director of Nursing to discuss findings and need for further auditing. Date of completion: April 10, 2013	

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F 280	Continued From page 12 wearing them consistently everyday. R53 further stated she placed the dentures in a denture cup and poured mouthwash over them when not in use. Dental consults revealed R53 had a dental visit on 12/17/13, 1/7/13, ("Rims for new dentures. Next visit will be trying on 1/4/13, appointment after that the patient should get dentures), 1/14/13, 1/18/13 and 2/17/12." R53's care plan dated 8/29/12 identified the resident as requiring assist with activities of daily living due to weakness. The resident was identified as "unmotivated" to do things for self. A grooming intervention indicated, "I need assist of one. I have my own teeth. On good days I can brush them after set up. Assist as needed." The care plan did not identify R53 denture's or relevant care interventions. When interviewed on 3/1/13, at 9:00 a.m. the trained medication aide (TMA)-A stated R53 was recently fitted for dentures but did not consistently wear them. The TMA-A further stated staff brushed R53's dentures when she wore them. A nursing assistant (NA)-D was interviewed on 3/1/13, at 10:53 a.m. and stated R53 had new dentures which were cleaned by staff when she wore the dentures. Registered nurse (RN)-C said on 3/1/13, at 10:53 a.m. R53 "just got her dentures but is not wearing them."	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		

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F 282	Continued From page 13 The services provided or arranged by the facility must 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 ensure repositioning and toileting was completed according to the care plan for 1 of 4 residents (R29) reviewed for positioning and the facility failed to ensure Bracemasters International-ankle foot orthotic (BMI-AFO) boots were applied according to the care plan for 1 of 3 residents (R65) reviewed for pressure ulcers. Findings include: R29 was not toileted and repositioned every two hours according to the comprehensive care plan. During observation on 2/28/13 R29 waited three hours and 19 minutes before being toileted. R29 was admitted in 2/13 and was receiving hospice care. A skin risk data collection and assessment dated 2/7/13, indicated R29 was incontinent of bladder and at risk for skin breakdown. Nursing note dated 2/27/13, indicated R29 had a stage II pressure ulcer over the coccyx that had healed and to continue to reposition R29 every two hours or as needed. The care plan directed staff to check R29 every two hours and as needed. On 2/28/13, R29 was observed lying on back in bed from 7:34 a.m. until 10:53 a.m. R29 remained on her back for three hours and 19	F 282	F282 Care plan and care guide updated on R65. R29 Expired on 3/2/13. Policy regarding Care Plans – Comprehensive and Using the Care Plan will be reviewed and updated by Director of Nursing or designee. All staff will be educated on policies by Director of Nursing or designee. Re-occurrence will be prevented by the Director of Nursing or designee completing the following audits: 1. Whole house audit will be completed to ensure all resident care plans and care guides match and are accurate. 2. Whole house audit will be completed to determine all residents who need an orthotic. 3. All new admissions will be audited weekly to determine if there is a need for an orthotic.	

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F 282	Continued From page 14 minutes. During interview on 2/28/13, at 1:58 p.m. nursing assistant (NA)-A indicated R29 was repositioned around 8:17 a.m. onto back and at 11:11 a.m. onto side. NA-A confirmed R29 was to be repositioned every two hours and verified was not repositioned every two hours that morning. During interview on 3/1/13, at 8:24 a.m. the director of nursing (DON) verified the care plan directed staff to turn and reposition R29 every two hours for incontinence care and as needed. The DON indicated the expectation was residents were repositioned every two hours according to the facility's policy. R65 was not wearing BMI-AFO boots as directed by the care plan. During an observation on 2/28/13, at 11:45 a.m. R65 was sitting up in a specialized wheelchair, however, was not wearing a BMI-AFO boot on either foot. R65 had diagnoses including quadriplegia and had a deep tissue injury on the right heel as of 2/20/13. A BMI-AFO boot was ordered and observed to be located in the bedroom available for use. The nursing assistant care sheet indicated R65 wore left and right BMI-AFO boots at all times. The resident's care plan dated 3/1/13 indicated BMI-AFO boots were used to relieve pressure of the foot, ankle, toes and heel. The director of nursing (DON) stated during an interview on 3/1/13, at 7:44 a.m. that the nursing assistant care sheets for R65 directed staff to	F 282	4. 5 Residents will be randomly audited per week to ensure repositioning is completed per the care plan. 5. 5 Residents will be randomly audited per week to ensure toileting is completed per the care plan. 6. 5 Audits will be randomly completed per week to ensure orthotics are in place per the care plan. All information will be brought to QA by Director of Nursing to discuss findings and need for further auditing. Date of completion: April 10, 2013	

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F 282	Continued From page 15 ensure the BMI-AFO boots were utilized all times. The DON then stated the boots were to be on while the resident was in bed and off while seated in the chair per the care plan dated 1/13/13, although it was verified the NA assignment sheets were also part of the resident's care plan, and directed staff to ensure they were worn at all times. The DON verified there was no documentation related to R65 refusing to wear the BMI-AFO boots.	F 282		
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, and interview, the facility failed to ensure appropriate positioning had been provided to promote independence in eating for 1 of 4 residents (R50) reviewed for positioning. Findings include: R50 sat in a wheelchair (w/c) with a right arm rest to support her arm and to provide adequate positioning at the dining room table to promote the resident's independence. On 2/26/13, at 8:30 a.m. R50 was seated in a w/c with a right arm rest. The w/c was positioned sideways along the dining table surface and the resident used her left hand to reach her eggs and	F 309		

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F 309	Continued From page 16 toast in a deep dish plate. While reaching to get a scoop of eggs R50 pulled the entire plate unto her lap, spilling the food onto her clothing. Although R50 put the toast and plate back on the table, only a few eggs remained on the plate. R50 again had to reach to get the toast. Staff made no attempt to reposition R50's w/c to make it easier to reach her food. On 2/28/13, at 12:30 p.m. R50 was positioned back away from the dining table surface. R50's plate and beverages were placed on the right arm rest and R50 was observed eating independently. R50 was admitted on 3/30/12 with diagnoses including a stroke. The quarterly Minimum Data Assessment (MDS) dated 1/28/13, indicated R50 was independent with eating and required set up help only, had short/long term memory impairment, and was dependent on staff assistance for wheelchair locomotion. According to a nursing assistant (NA)-A on 2/28/13, at 11:01 a.m. R50 was able to eat independently and had a lap table on the wheelchair. Her plate and beverages were either placed on the w/c tray or the resident's w/c was lined up to the table. The resident preferred using the table, as the tray was not very sturdy. NA-A stated R50 was positioned at the table during meal times in both of the above mentioned ways. NA-A stated she thought R50 would rather be placed at the table as sometimes R50's plate fell off the tray onto the wheelchair or floor and sometimes spilling food into lap. The director of nursing (DON) said on 3/1/13 at 9:57 a.m., that it was expected R50 to be	F 309	F309 OT screen completed for R50 for positioning during meal times and care plan updated. Policy regarding Assistance with Meals will be reviewed and updated by Dietitian or designee. All staff will be educated on policy by Administrator or designee. Re-occurrence will be prevented by the Administrator or designee completing the following audits: 1. Whole house audit will be completed to ensure proper positioning during meal times is in place for all current residents. 2. All new admits will be reviewed to ensure proper positioning during meal times. 3. 5 Residents will be randomly audited per week to ensure proper positioning during meal times. All information will be brought to QA by Administrator to discuss findings and need for further auditing. Date of completion: April 10, 2013	

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F 309	Continued From page 17 positioned close enough to the table that she could use her left hand to eat independently. The DON confirmed R50 was not consistently positioned the same way at the dining room table during meal times. The resident's w/c was angled alongside the dining room table, so she would be able to access food, silverware, and drinks better. The DON stated R50 should not have been positioned at the dining room table with plate and beverages on right arm rest at mealtime. She should have instead been positioned straight toward the table in the w/c with food and beverages placed on the dining room table.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to minimize the risk of pressure ulcer (PU) development and promote healing of exiting PU for 1 of 3 residents (R33) reviewed with a current PU. Findings include:	F 314		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 314	Continued From page 18 R33 developed a Stage 2 PU (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough. May also present as an intact or open/ruptured blister) on 2/22/13, however, a comprehensive assessment of the wound, potential causal factors, and interventions to minimize the risk of further skin breakdown was not completed until 2/28/13. In addition, the resident was observed in the w/c for three hours and five minutes without repositioning and had a skin assessment that indicated the resident should be repositioned at a minimum every two hours. Also the resident's w/c was an inappropriate fit as it appeared to be too small to comfortably accommodate R33's body size and the w/c lacked a cushion to reduce friction and pressure while seated in the wheelchair for long periods of time especially if a resident has a PU located on the buttocks. During observation on 3/1/13, at 1:33 p.m. registered nurse (RN)-C removed an Optifoam dressing (dressing with silicone adhesive border and water proof backing) from R33's right buttock. A small dime-sized open area was observed on the right buttock. The tissue upon the wound bed appeared pink and the tissue surrounding the wound was intact. RN-C cleaned the surrounding tissue with wound cleanser and applied a new Optifoam dressing. Observations on 2/27/13, at 1:45 p.m. R33 was lying on his back in bed. A large cotton incontinent pad was positioned under R33. No pressure reduction devices were observed on the bed or in R33's w/c which was adjacent to the bed.	F 314	F314 R33 had new skin assessments completed (Tissue Tolerance 2/27, Braden Scale 2/28 and Skin Risk Data Collection 2/28). Resident was given a pressure relieving mattress and pressure relieving cushion which improved his wheelchair positioning. R33's care plan was updated. Policy regarding Pressure Ulcers/Skin Breakdown – Clinical Protocol and Repositioning will be reviewed and updated by Director of Nursing or designee. All staff will be educated on policies by Director of Nursing or designee. Re-occurrence will be prevented by the Director of Nursing or designee completing the following audits: 1. Whole house audit will be completed to ensure all residents have a proper fitting wheelchair and pressure relieving cushion.	

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F 314	Continued From page 19 On 2/28/13, at 7:10 a.m. R33 was up in the w/c sitting in lobby area. There was no cushion observed in R33's w/c and his knees extended over the foot pedals of the w/c. At 9:20 a.m. nursing assistant (NA)-B wheeled R33 out of the dining room. At 10:15 a.m. R33 was assisted to the bathroom by NA-B and trained medication aide (TMA)-A. R33 had been sitting in the w/c from 7:10 a.m. until 10:15 a.m. (three hours and five minutes) with no change of position. The resident ambulated approximately eight feet with a walker and assistance of staff into the bathroom. R33's incontinent pad was dry. R33 developed a PU on 2/22/13. A fax was sent to the physician stating, "Resident was getting cleaned up and writer noticed an area to right buttock (1 cm. in length) opened area. Writer applied an opti-foam after cleaning. On left buttock is a 1.5 cm. in length scab. Cleansed this area, left opened to air. Can we get an order for Optifoam or equivalent and change every 3 days and prn [as needed]." A progress note on 2/28/13, at 4:22 p.m. indicated "Wound is Stage II PU located on left inner buttock. Wound measures 2 cm. x 1 cm. Wound bed is red, no slough noted." No other assessments of the PU were conducted since 2/22/13. The annual Minimum Data Set (MDS) assessment dated 2/12/13, identified R33 as having severe cognitive impairment, and requiring total assistance with bed mobility, extensive assistance with transferring and limited assistance with walking. The MDS also identified R33 as being always incontinent of bladder and	F 314	2. Whole house audit will be completed to ensure all residents with current skin breakdown, or at a high risk for skin breakdown, have appropriate interventions in place for prevention and/or healing. 3. All new admits will be audited weekly to ensure they have a proper fitting wheelchair and pressure relieving cushion in place. 4. All new admits will be audited weekly to ensure appropriate interventions are put in place, if appropriate, for prevention and/or healing of skin breakdown. 5. 5 residents will be randomly audited per week to ensure repositioning is completed per the care plan. 6. All new skin incidences will be reviewed weekly to ensure they are assessed properly and appropriate interventions are put into place timely. All information will be brought to QA by Director of Nursing to discuss findings and need for further auditing. Date of completion: April 10, 2013	

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F 314	Continued From page 20 bowel and needing extensive assistance with toileting. The Care Area Assessment (CAA) summary for PUs identified R33 as being at risk for skin breakdown due to being incontinent of bowel and bladder and being resistive with activities of daily living but identified no current skin issues. The quarterly Braden scale for predicting PU risk dated 2/6/13, identified R33 as being at low risk for PU development. The tissue tolerance assessment completed on 2/27/13, indicated R33 could tolerate being in the same position for two hours with no negative skin outcomes. The care plan dated 4/13/11, identified R33 as being at risk for PU development related to diagnosis of cognitive impairment, dependent mobility, incontinence, and history of PUs. The intervention included reposition every two hours and as needed during the day and evening with assist of one staff, and could reposition self in bed at night; monitor nutritional status; obtain and monitor lab/diagnostic work as needed; inform resident/family/caregiver/MD of any new skin areas; and follow facility polices for the prevention of skin breakdown. Further review of the care plan identified R33 as having a activities of daily living self-care performance deficit related to dementia, confusion, and could become resistive at times with transfers related to pain, dementia, and language barrier. The interventions indicated assist of one staff to get in and out of bed, sit up, lift legs into bed, would not turn self in bed, works better for two staff to reposition as resistive with cares. Requires stand by assist of one staff with cueing with ambulation. When interviewed on 2/28/13, at 1:20 p.m. the	F 314		

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F 314	Continued From page 21 registered nurse (RN)-C stated the therapy staff provided appropriate w/c for residents based on the resident size and needs. RN-C further stated that upon admission to the facility, a resident sometimes used a w/c short term, but if a w/c was needed for frequent or long term use, the resident was referred to therapy. A physical therapy assistant (PTA)-A was interviewed on 2/28/13, at 2:10 p.m. The PTA did not think R33 used a w/c all the time as the resident generally walked to meals. When interviewed on 2/28/13, at 2:16 p.m. NA-B stated R33 sometimes used a w/c if he refused to walk. The PTA was then re-interviewed on 2/28/13, at 2:30 p.m. and stated had reviewed R33's positioning in the w/c and that the w/c was inappropriate for the resident's body size. The PTA then added a w/c cushion, which improved the resident's positioning. When interviewed on 2/28/13, at 3:05 p.m. the director of nursing (DON) stated a comprehensive assessment of the wound on the left buttock had not yet been completed. The DON further stated had interviewed a NA and nurse, who both thought the area was a scratch. The DON also indicated R33 did not consistently use a w/c for more than a ride to the dining room if R33 refused to walk. Current PU interventions for R33 included barrier cream, repositioning, and ambulation to destinations outside of room. The DON confirmed a comprehensive assessment of R33 should have been completed at the time the wound was noted and should have included the	F 314		

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F 314	Continued From page 22 current PU prevention interventions, mobility needs (including current use of a w/c), and nutritional needs. Further interview with the DON on 2/28/13, at 4:45 p.m. indicated the wound was assessed at 4:22 p.m. and was identified as a Stage 2 PU.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess the need for an indwelling foley catheter for 1 of 3 residents (R49) reviewed for urinary catheter use. Also the facility failed to identify three symptoms for an active urinary tract infection (UTI) before starting antibiotic therapy for 1 of 1 resident (R43) reviewed for urinary incontinence. Findings include: R49 had been admitted to the facility on 11/27/12, with diagnoses that included cerebrovascular accident, diabetes and urine retention. The significant status change Minimum	F 315	F315 R49 had a new Urinary Continence Evaluation completed on 2/28/13. Staff were educated on ensuring 3 symptoms are documented for a resident who has a UTI before antibiotics are started. Policy regarding Urinary Tract Infections/Bacteriuria – Clinical Protocol and Urinary Continence and Incontinence – Assessment and Management will be reviewed and updated by Director of Nursing or designee. All nursing staff will be educated on policies by Director of Nursing or designee. Re-occurrence will be prevented by the Director of Nursing or designee completing the following audits:	

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F 315	Continued From page 23 Data Set (MDS) dated 12/18/12, identified R49 required extensive assistance with two plus staff with transfers, dependent with one staff with toileting, always incontinent with bladder and with no toileting plan and no indwelling catheter present. During observation on 2/27/13 at 3:09 p.m., R49 was observed lying in bed with clear tubing containing urine draped over the left side of the bed and drained in a covered bag attched to the side of the bed. During review of the most current bladder assessment dated 12/6/12, it identified R49 was incontinent of bladder and had no indwelling foley catheter. However, no further comprehensive assessment was completed after the indwelling Foley catheter was placed. Current physician orders dated 1/29/13, directed staff on the care of the Foley catheter. Requested copy of bladder assessment and had not received the copy of the bladder assessment dated 12/6/12. During review of the comprehensive care plan R49 had a foley catheter related to chronic urinary retention. Also R49 had surgery in December 2012 to removed stones from the bladder. During interview on 3/1/13 at 8:01 a.m., the director of nursing (DON) indicated that the December 6, 2012 evaluation indicated R49 had a catheter removed last week. DON reviewed progress notes on 11/21 catheter changed tonight minimal output, 11/27/12 resident had no catheter and had voided twice large amount and on 11/30/12 resident voided twice today large	F 315	1. Whole house audit will be completed to ensure all residents with a catheter have an appropriate urinary assessment in place. 2. All new admits with catheters will be audited weekly to ensure they have an appropriate urinary assessment completed. 3. Infection Control Log will be audited weekly and reviewed with nursing documentation to ensure all residents started on an antibiotic for a UTI had 3 symptoms present. All information will be brought to QA by Director of Nursing to discuss findings and need for further auditing. Date of completion: April 10, 2013	

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F 315	Continued From page 24 amount of urine. DON indicated the note on December 11, 2012 revealed that the resident returned from an appointment and had a foley catheter placed and it is still present. The DON confirmed there should have been an assessment done after the placement of the catheter. R43 received antibiotic therapy for a urinary tract infection (UTI) even though there were less then three medical symptoms identified before starting the antibiotic treatment. R43 had diagnoses that included depression, anxiety, psychosis, and dementia. During review of the medical record it was noted that on 1/7/13, R43's physician ordered a urinalysis/urinary culture (UA/UC) due to foul smelling urine and increased behavior. Review of progress notes 11/29/12, to 1/9/13, revealed no documentation of symptoms related to a UTI including the presence of foul smelling urine or increased behavior. Progress note dated 1/9/13 at 11:24 p.m. indicated a fax had been sent to the physician related to UA/UC results, no symptoms had been identified on this fax either. On 1/10/13, the physician ordered Amoxil (antibiotic) 500 mg (milligrams) one tablet three times a day for 14 days for UTI. During interview on 3/1/13, at 10:11 a.m. the director of nursing (DON) confirmed no documentation had been identified to indicate R43 had a minimum of three symptoms of a UTI to justify the use of antibiotic. DON stated the expectation was three symptoms were required to treat with an antibiotic.	F 315		

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F 315	Continued From page 25 Urinary Tract Infection policy dated 2/27/13, directed nurses to observe, document and report signs and symptoms in detail and avoid premature diagnostic conclusions. The policy indicated new onset of nonspecific symptoms alone (change in mental status, decline in appetite, etc) is not a reliable indicator of a UTI unless there are other general or localized symptoms. Urine odor and cloudiness do not necessarily indicate bacteriuria or UTI. The policy identified three symptoms must be present to diagnosis UTI in a long term care resident who does not have an indwelling catheter.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure range of motion services were provided for 2 of 3 residents (R28 and R53) reviewed for range of motion. Findings include: The facility failed to ensure that R28 utilized a left hand brace as recommended by an occupational therapy (OT) staff. Although staff said the resident refused to wear the splint, communication to the certified occupation therapy	F 318	F318 R53 discharged from the facility on 3/20/13. R28 re-assessed by OT and new therapy recommendations for range of motion provided. R28's care plan reviewed and updated. Policy regarding Rehabilitative Nursing Care and Range of Motion Exercises will be reviewed and updated by Director of Nursing or designee. All staff will be educated on policies by Director of Nursing or designee.	

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F 318	Continued From page 26 aide (COTA) and interventions to address the problem were not implemented. R28 was observed on three different occasions during the day, and at no time was she wearing a splint. Observations of the resident were on 2/27/13, at 1:11 p.m., on 2/28/13, at 7:18 a.m., and again on 2/28/13, at 9:02 a.m. A physician's progress note dated 12/19/12, indicated an order for left hand brace per OT staff. An OT staff's note dated 12/19/12 read, "Therapy Recommendations for splints/braces" and directed staff to apply a left hand brace to be worn at bedtime only, unless patient requested to wear it during day as it felt more comfortable being supported. Also, "Monitor for redness, pressure areas." R28's diagnoses included degenerative joint disease, arthritis in hands, history of shingles (left hand). A significant change Minimum Data Set (MDS) assessment dated 1/7/13, identified R28 as having moderate cognitive impairment and no range of motion issues were identified. The care plan dated 2/6/13, indicated R28 required assistance with mobility due to generalized weakness, history of falls, restless leg syndrome, degenerative joint disease, arthritis in hands and recent shingles (left hand) with residual nerve pain. The interventions directed staff to transfer and ambulate the resident with the assistance of one staff. The care plan did not include any provision regarding the use of a left hand hand brace. When interviewed on 2/26/13, at 2:15 p.m. the	F 318	Re-occurrence will be prevented by the Director of Nursing or designee completing the following audits: 1. Whole house audit will be completed to identify any contractures and therapy will make recommendations for range of motion and/or splinting. Care plans will then be reviewed and updated. 2. All new admissions will be audited to identify any contractures and therapy will make recommendations for range of motion and/or splinting. Care plans will then be reviewed and updated. 3. 5 Residents will be randomly audited per week to ensure splints are applied as directed. 4. All residents in restorative will be reviewed weekly. Any refusals will be reviewed to ensure a plan is in place to promote participation in the program, as well as interventions to maintain their current level of functioning.	

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F 318	Continued From page 27 director of nursing (DON) stated that R28 had bilateral contractures of the hands, but refused to wear braces. Nursing assistant (NA)-C reported at 2/27/13, at 1:13 p.m. that R28 did not wear any splints or braces on her hands. When interviewed on 3/1/3, at 1:09 p.m. the certified occupational therapist aide (COTA)-G stated she was asked by the physician to obtain a left hand brace for R28 to keep the resident's hand open and prevent further contracture of her hand, as she had been holding hand in a somewhat closed position. The COTA stated she obtained a brace for the resident to wear at night, but R28 instead expressed interest in wearing brace during the day. The resident required assistance to apply the brace, as the resident had cognitive issues. Staff had been educated was completed and a program for splint application was developed. The COTA then went to R28's room to locate the brace, which was found in the bottom of the resident's dresser drawer. The COTA stated she was unaware the resident was not wearing the splint. R53's restorative nursing rehabilitation was discontinued, however, a plan was not developed to address limitations in lower extremity to minimize the risk of contractures. On 2/26/13 at 9:40 a.m. R53 was in a wheelchair in her room. The resident reported to the surveyor that she was unable to walk. On 2/27/13, at 1:04 p.m. R53 was wheeling self in wheelchair. The quarterly MDS assessment dated 1/9/13,	F 318	All information will be brought to QA by Director of Nursing to discuss findings and need for further auditing. Date of completion: April 10, 2013	

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F 318	Continued From page 28 identified R53 as having no cognitive impairment, needing extensive assist with bed mobility, transferring, walking in room and no walking in corridor and lower extremity impairment on both sides. The care plan (CP) dated 8/29/12, indicated R53 needed staff assist with mobility due to weakness as a result of dementia, Parkinson disease, and chronic right leg pain, required the use of a wheelchair, and at times the resident was "unmotivated" to do things for herself. Interventions directed staff to assist of one and wheeled walker with ambulation. If the resident was short of breath or was tired, she only took a few steps. After the resident completed OT on 9/11/12, and physical therapy (PT) on 10/12/12. "I was tried on on restorative nursing program (walking and exercise) to maintain my current strength level. As of 11/5/12 I was taken off due to lack of interest and participation." The plan did not include encouraging the resident to participate, or other interventions to help the resident maintain current level of range of motion. When interviewed on 2/26/13, at 2:13 p.m.. the director of nursing (DON) stated that R53 has a contractures of right ankle but refused to walk with staff or work with therapy. Restorative NA-E reported on 3/1/13, at 10:32 a.m. that R53 had been on a restorative program for about a month and was walking approximately 75-100 feet (in room and outside of room) but was refusing to participate approximately 50% of the time, therefore, the program was discontinued.	F 318		

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

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F 318	Continued From page 29 When interviewed on 3/1/13, at 2:41 p.m. trained mediation aide (TMA)-A stated resident was not on a walking program and does not walk outside of room with staff. Although the facility indicated R53 declined to ambulate with restorative nursing no interventions were in place to promote participation with ambulation or interventions to maintain current range of motion abilities.	F 318		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal 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 legal 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 legal 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	F 334	F334 R43 was given the influenza vaccination on 3/7/13. R33 was given the influenza vaccination on 3/26/13. Policy regarding Influenza Vaccine will be reviewed and updated by Director of Nursing or designee. All licensed nursing staff will be educated on policy by Director of Nursing or designee. Re-occurrence will be prevented by the Director of Nursing or designee completing the following audits: 1. Whole house audit will be completed to ensure the influenza vaccination was given or documentation reflects that it was offered and refused.	

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F 334	Continued From page 30 contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal 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 legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.	F 334	2. All new admissions will be audited until March 31, 2013 to ensure the influenza vaccination is offered and documented. All information will be brought to QA by Director of Nursing to discuss findings and need for further auditing. Date of completion: April 10, 2013	

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F 334	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure annual influenza vaccinations were offered and documented for 2 of 5 residents (R33, R43) reviewed for immunizations. Findings include: R33 and R43's medical records lacked evidence they had been offered annual influenza immunization, or whether they had declined the immunization and if so reasons why. R33 was not offered influenza immunization since 10/24/11. An Immunization Record revealed R33 received the influenza vaccine on 10/24/11, however, evidence of offers for immunization after that date were not noted. R43 was not offered an influenza immunization since 9/27/11. An Immunization Record revealed R43 received the influenza vaccine on 9/27/11, however, evidence to show any immunization after that date was not found in the record. Although a quarterly care conference note for R43 dated 1/2/13, stated, "Refused flu shot--will approach again," no follow up was completed with R43, nor was the reason for refusal noted. The director of nursing was interviewed 2/28/13, at 3:02 p.m. and verified R33 and R43 had not been offered influenza immunization during the current flu season. The facility policy for Influenza Vaccine dated	F 334		

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F 334	Continued From page 32 12/07, indicated all residents and employees who had direct contact with residents would be offered the influenza vaccination annually to encourage and promote the benefits associated with vaccinations against influenza. For those who received the vaccine, the date of the vaccination, lot number, expiration date, person administering, and the site of vaccination was to be documented in each resident's medical record, and should a resident refuse vaccination, it was to be noted in the record, as well.	F 334		
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure finger foods were provided according to recommendations from dietitian and occupational therapy (OT) for 1 of 1 resident (R66) in the sample reviewed for assistance with activities of daily living. Findings include: R66 was not provided with finger foods as recommended by OT and the dietitian to promote the resident's ability to eat independently. Observations on 2/28/13, at 8:30 a.m. revealed R66 was given a breakfast tray consisting of toast, scrambled eggs, cut up bananas in a bowl and dry Fruit Loop cereal in a bowl. Nursing assistant (NA)-B sat down and assisted R66 to	F 365	F365 R66's dietary care plan reviewed and updated. Dietitian followed up with R66's physician on 1/10/13 and noted that resident's weight discrepancy was a scale error. Her weight has been stable since admission to the facility. Policy regarding Therapeutic Diets and Menus will be reviewed and updated by Dietitian or designee. All staff will be educated on policies by Administrator or designee.	

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F 365	Continued From page 33 eat breakfast. The NA cut up toast and gave R66 bites using an adaptive fork. The NA then left the resident to assist others in the dining room, and returned at 8:41 a.m. Two minutes later the NA left R66 to assist another resident on the other side of the table. R66 attempted to picked up scrambled eggs with fingers. At 8:48 a.m., NA-B returned to assist R66 using the adaptive spoon to feed him scrambled eggs and bananas. R66 picked up the spoon without scooping food and put the spoon into his mouth. He then pulled the bowl of dry cereal onto the lap and ate the dry cereal one piece at at a time. Food items provided at the noon meal for R66 on 2/28/13 at 12:15 a.m., had been sliced turkey, dressing, mixed vegetables, and J-ello. No "finger foods" were provided to enhance the resident's ability to self-feed. R66's Minimum Data Set dated 1/14/13, identified the resident had short and long term memory deficit, required limited assistance (resident highly involved in activity) to eat a therapeutic diet. The care plan dated 2/24/13, revealed R66 had no nutritional or potential problems. Physician orders 1/30/13 revealed an order for a regular diet. R66's dietary card indicated preferences for finger foods for R66 to pick up at mealtime. An OT note on 1/16/13 directed staff to utilize finger foods at meal times, and a subsequent note on 1/18/13, indicated R66 was unable to comprehend simple activities of daily living tasks such as eating with utensils. A Dietary Profile and Risk Assessment dated 1/9/13, indicated R66's daughter reported to dietitian that the resident's usual body weight was	F 365	Re-occurrence will be prevented by the Administrator or designee completing the following audits: 1. Whole house audit will be completed to ensure all residents are on the appropriate diet and have adaptive equipment to promote their ability to eat independently. 2. All new admissions will be reviewed to ensure they are on the appropriate diet and have adaptive equipment to promote their ability to eat independently 3. 5 Residents will be randomly audited per week to ensure foods and adaptive equipment are provided to promote independence with eating. All information will be brought to QA by Administrator to discuss findings and need for further auditing. Date of completion: April 10, 2013	

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	245383	A. BUILDING _____ B. WING _____	03/01/2013

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F 365	Continued From page 34 134 pounds and current weight was 112 pounds. The registered dietitian (RD) planned to confirm the resident's weight with the physician's nurse. The assessment continued to indicate R66 was eating well when provided finger foods, and was unable to use silverware due to severe cognitive deficits. Registered nurse (RN)-A said in an interview on 3/1/13 at 8:31 a.m. that R66 may start feeding self, but to the best of the RN's knowledge, the resident needed assistance to eat. RN-A said the occupational therapist had felt the resident's cognition was severe enough that R66 could not use adaptive silverware. The director of nursing (DON) was interviewed on 3/1/13 at 8:38 a.m., and stated that R66 should have been provided finger foods. An interview was conducted on 3/1/13 at 8:55 a.m. with the registered dietician (RD.) The RD said R66 was able to feed self, but required supervision and staff assistance. The adaptive equipment recommendation had come from the occupational therapist. The RD verified R66 did better with finger foods, and was able to feed self when provided finger foods. NA-B was interviewed on 3/1/13 at 9:17 a.m. and said R66 ate with fingers and could eat independently at times. The NA said the resident liked to eat with fingers and did very well at meals when those foods were provided. If finger foods were not offered, the resident had to be fed. Cook-A was interviewed on 3/1/13 at 9:24 a.m. and said R66 was provided finger foods at each	F 365		

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F 365	Continued From page 35 meal, but said the facility needed more finger food to offer the resident. The cook explained that R66 had not been offered a lot of finger foods unless the staff requested them, and said the resident was able to use the adaptive equipment to eat. Although finger foods were not always available, the cook said they tried to make sure R66 had some at each meal. Cook-A worked during the noon meal on 2/28/13, and verified no finger foods were offered to R66. The dietary manager stated in an interview on 3/1/13 at 11:03 a.m., that the care plan did not address the need to provide finger foods to enhance the resident's independence in eating.	F 365		
F 371 SS=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 maintain food service areas in good repair and in a sanitary manner, potentially affecting 40 of 40 residents residing in the facility. Findings include:	F 371	F371 New flooring was installed in the kitchen The kitchen walls were all re-painted. The wall with a black raised substance was treated twice with Kilz and then re-painted. The plate warmer was cleaned. The exhaust hood was serviced and is in working condition. The rust was sanded off and the hood was re-painted. Shelves in the walk-in cooler were cleaned. Cabbage and lettuce involved in the spill was disposed of.	

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F 371	Continued From page 36 During the kitchen tour on 2/27/13 at 9:15 a.m. with the designated dietary manager (DM) the following concerns were identified: The wall behind the three compartment sink had paint flaking off and raw cement exposed. This created a risk for sanitation for the items placed in the three compartment sink which was used to clean pots and pans and created an unclean and a non-sanitized surface. Also the wall located by the window and just above the clean dish rack had a one by one foot area covered with a black raised substance (like mold) and there were two racks of clean dishes that had been removed from the dishwasher and were air drying located below this area. The flooring in the entire kitchen which included the pantry and hallway to the freezer had multiple chips missing especially in the area of the dishwasher, multiple gouges and cracks, heavy build-up of dark debris around the entire kitchen wall between the floor surface and base cove. This created a non-sanitized surface. The metal sides of the plate warmer was smeared with debris and appeared greasy. The exhaust hood fan located above the dishwasher was non-functioning. The metal exhaust hood had areas of chipped paint and rust around the edges and a large rust area on the inner side of the hood. This hood was located directly above the dishwasher. There were six shelves in the walk in cooler where milk and other juices were stored. The	F 371	Refrigeration Company serviced walk-in cooler to address condensation from pipes. All chemicals were moved and are stored away from food and food equipment. Policy regarding Sanitization and Cooks Weekly Cleaning List and Dietary Aide Weekly Cleaning List will be reviewed and updated by the Dietitian or designee. All dietary staff will be educated on policy and cleaning schedules by Dietary Manager or designee. Re-occurrence will be prevented by the Administrator or designee completing the following audits: 1. 5 Audits will be randomly completed per week to ensure cooks and dietary aides are completing cleaning per weekly cleaning list. All information will be brought to QA by Dietary Manager to discuss findings and need for further auditing. Date of completion: April 10, 2013	

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F 371	Continued From page 37 shelves had debris and hanging debris on the metal where the food containers came in contact with the wire shelves. Pipes from the condenser ran across the upper food storage shelf and water from the pipes were dripping and pooling on top of a large plastic container of mayonnaise, and salad dressing, creating an environment for bacterial growth and a potential for foodborne illness. Also there was cabbage, lettuce, in a box that had liquid Jell-O on them being stored on the shelves. The staff present explained that a tray of Jell-O was placed above the vegetable and had spilled on the cabbage and lettuce but they were not cleaned immediately after the spill occurred. There were containers of hazardous chemicals stored on the top shelf of the metal rack and two spray bottles of hazardous chemicals had been hung on the side of the top shelf rack. The metal rack was located across from the dishwasher. The shelves located below the chemicals had dishwasher trays used to hold the dishes when they go through the dish washer. All other chemicals were located in a separate area that was not near food or food equipment. The chemical included Quat Stat SC, a spray bottle that contained Quat Stat SC and a spray bottle that contained Comet with bleach and all these chemicals were noted to be hazardous to humans. A cleaning schedule titled Cooks Weekly Cleaning List and the Dietary Aide Weekly Cleaning List listed weekly and daily tasks. The cleaning tasks for the cooks included cooler shelves/walls/floors to be completed on Sundays. The plate warmer inside and out to be completed on Tuesdays. The cleaning tasks for the dietary	F 371		

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F 371	Continued From page 38 aide included dish machine/underneath wall to be completed on Sunday. Scrub floor/pipes underneath the dish machine to be completed on Tuesday. The wall behind the dish room to be completed on Friday. During an interview on 2/27/13 at 9:15 a.m., during the kitchen tour, the dietary manager (DM) noted the concerns and said they had a kitchen cleaning schedule that outlined daily tasks for both the dietary aides and the cooks. During an interview on 2/27/13 at 9:35 a.m., the administrator stated the floor in the kitchen had been placed on the list for a capital improvement project. The facility had received bids for the flooring and planned to have the floor replaced this year, however, a date had not been set for installation. She also observed the dark raised debris (like mold) on the wall by the dishwasher and confirmed it could have been related to the inoperable exhaust fan over the dish washer. A policy titled Sanitization dated 2/28/13 read, "The food service area shall be maintained in a clean and sanitary manner...All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair...."	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program	F 441	F441 A case study was completed on UTI's and a plan was put in place to monitor and correct the problem.	

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F 441	Continued From page 39 The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to adequately disinfect a multi-use glucometer according to the facility policy and acceptable infection control practices for 1 of 7 residents (R57) in the sample who utilized the glucometer and failed to identify a	F 441	Policy regarding Urinary Tract Infections/Bacteriuria – Clinical Protocol, Policies and Practices – Infection Control, Monitoring Compliance with Infection Control, and Obtaining a Fingerstick Glucose Level will be reviewed and updated by Director of Nursing or designee. All nursing staff will be educated on policies by Director of Nursing or designee. All licensed nursing staff and TMA's will demonstrate competency in sanitizing the glucometer. All nursing assistants will demonstrate competency in peri-care. Reoccurrence will be prevented by the Director of Nursing or designee completing the following audits: 1. 5 Audits will be randomly completed per week to ensure staff are properly sanitizing the glucometer. 2. 5 Audits will be randomly completed per week to ensure staff are completing peri-care properly. All information will be brought to QA by Director of Nursing to discuss findings and need for further auditing. Date of completion: April 10, 2013	

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F 441	Continued From page 40 high number of urinary tract infections (UTIs) for 15 of 15 residents (R5, R6, R20, R23, R26, R37, R39, R42, R43, R48, R49, R66, R68, R69 and R80) who were treated with antibiotic medication and develop a plan to monitor and correct the problem. Findings include: The multi-use glucometer had not been sanitized after resident use to minimize the risk of blood borne pathogens (infections) through cross-contamination. During observation on 2/26/13, at 7:38 a.m. a licensed practical nurse (LPN)-A carried a tote from the medication cart that contained a glucometer-blood glucose testing machine, cotton balls, sharps container, lancets, and test strips. LPN-A washed her hands, put on gloves and removed the glucometer from the carrying tote. LPN-A then wiped the glucometer for 10 seconds with a disinfectant wipe and placed it directly on the nurses' desk without placing a barrier between the glucometer and the counter. LPN-A then cleansed R57's finger with an alcohol wipe, prepared the glucometer with a testing strip, pricked R57's finger with a lancet and obtained blood on the testing strip. After completion of the blood glucose check LPN-A removed the test strip and placed the glucometer back into the carrying tote without cleaning/sanitizing it. LPN-A then placed the tote back into the medication cart. LPN-A was interviewed after the observations at 7:42 a.m. and verified proper cleaning of the glucometer had not been performed prior to returning it to the tote for future use. LPN-A stated the glucometer was utilized by seven individual residents on the unit.	F 441		

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F 441	Continued From page 41 The director of nursing reported on 2/28/13, at 10:09 a.m. that there was one glucometer for use on each hallway, and the machines were to be wiped down after each use with a disinfectant wipe following the manufacturer's direction. A barrier between resident equipment and common work surfaces was also expected. The Facilities Obtaining a Finger-stick Glucose Level Policy, dated 2/27/13 directed staff to clean and disinfect reusable equipment between uses according to the manufacturer's instruction and current infection control standards of practice. The Medline Micro-Kill disinfecting wipes manufacturer's instruction for disinfection revealed direction to thoroughly wet surface, keep wet for two minutes and allow to air dry. The facility failed to identify a trend in resident UTIs and to implement a monitoring system and plan to decrease the prevalence of urinary tract infections. Infection control logs for 11/12 revealed eight residents (R5, R6, R20, R26, R39, R42, R49, R80) had acquired UTIs for a total of 14 incidences, eight of whom had indwelling catheter use. All but two of the eight residents had nosocomial/facility acquired UTIs, and all were prescribed antibiotics. Infection control logs for 12/12, revealed five residents (R6, R26, R37, R42, R49) had UTIs for a total of seven incidences, three of whom had indwelling catheter use, and four that had been nosocomial/facility acquired UTIs. All were	F 441		

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F 441	Continued From page 42 prescribed antibiotics. Infection control logs for 1/13, revealed five residents (R23, R43,R66, R68, R69) had UTIs for a total of six incidences, one of whom had indwelling catheter use. All but one of the five residents had nosocomial/facility acquired UTIs, and all received antibiotic medication to treat the infections. Nursing assistant (NA) training records from 11/25/12 to 2/25/12 revealed no training related to prevention of urinary tract infections. The director of nursing (DON) was interviewed on 2/28/13, at 9:05 a.m. and was unable to provide any documentation to show the facility had identified the prevalence or any patterns related to the UTIs, and there was no indication of monitoring or a plan to address the issue. The DON explained that infection control data was shared with the Quality Assurance (QA) committee, however, no information was available at the time to indicate the QA committee had addressed the incidence of UTIs. The Infection Control policy revised 8/11, revealed "The facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections." A revision dated 1/11/13 revealed, "The Quality Assurance Committee shall oversee, implementation of infection control policies and practices and help department heads and managers ensure that they are implemented and followed."	F 441		

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F 441	Continued From page 43 The Monitoring Compliance with Infection Control Policy dated 6/10, revealed "Routine monitoring and surveillance of the workplace will be conducted to determine compliance with infection control policies and practices. The infection Control Coordinator or designee shall monitor the effectiveness of out infection control work practices and protective equipment. Investigations of known or suspected transmission of healthcare associated infections."	F 441		
F 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility to ensure the safe operation of the steam table and the exhaust hood fan located over the dishwasher. This had the potential to affect the 40 residents who resided at the facility. Findings include: During the kitchen tour on 2/27/13 at 9:15 a.m. with the designated dietary manager (DM) the following concerns were identified: The steam table electrical cord created a safety hazard as the cord had pulled the electric components from inside the electric box that was fastened to the wall. The electric cord attached to the steam table was kinked due to the steam table pushing up against the electric cord and wall outlet. The kink was located near the plug and could have caused the electric wires to weaken	F 456	F456 The steam table was moved away from the wall so the cord is not kinked. The electrical outlet in the kitchen was replaced. The exhaust hood was serviced and is in working condition. The rust was sanded off and the hood was re-painted. The wall with a black raised substance was treated twice with Kilz and then re-painted. Policy regarding Electrical Safety Precautions and Maintenance Service will be reviewed and updated by Maintenance Director or designee. All staff will be educated on policies by Administrator or designee.	

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F 456	Continued From page 44 and break and/or created a safety risk for electrical shock from a 220 voltage outlet and potential fire hazard. In addition, the exhaust hood fan located above the dishwasher was non-functioning. The metal exhaust hood had areas of chipped paint and rust around the outer edges and a large rust area on the inner side of the hood. This hood was located directly above the dishwasher which was observed to give off visible steam when run. Also the wall located by the window and just above the clean dish rack had a one by one foot area covered with a black raised substance which appearing like mold. There were two racks of clean dishes that had been removed from the dishwasher and were air drying located below this blackened area. The DM explained that the black substance could have been related to excess moisture from running the dishwasher and the exhaust hood fan was inoperable. The administrator was then apprised of the concern on 2/27/13, at 9:35 a.m.	F 456	Re-occurrence will be prevented by the Administrator or designee completing the following audits: 1. 5 Audits will be randomly completed per week to ensure equipment is in safe operating condition. All information will be brought to QA by Maintenance Director to discuss findings and need for further auditing. Date of completion: April 10, 2013	

F 5383025

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

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	245383	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/28/2013

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OWATONNA CARE CENTER	201 SOUTHWEST 18TH STREET OWATONNA, MN 55060

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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. At the time of this survey, Owatonna Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	RECEIVED MAR 28 2013 POC ok JB 4-2-13	

DC: 04.10.2013
EXIT: 03.01.2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	3/28/13

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
	245383	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWATONNA CARE CENTER	201 SOUTHWEST 18TH STREET OWATONNA, MN 55060

(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
K 000	Continued From page 1 By email to: Barbara.Lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility will be surveyed as two separate buildings. Owatonna Commons Nursing & Rehab is a 1-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1958 and was determined to be of Type II(222) construction. In 1966, addition was constructed to the South Wing, with a partial basement and 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 to a Type II (111) building. The facility is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245383	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWATONNA CARE CENTER	201 SOUTHWEST 18TH STREET OWATONNA, MN 55060

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K 000	Continued From page 2 The facility has a capacity of 55 beds and had a census of 39 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide 2-hour rated construction at the building separation walls in accordance with 2000 - NFPA 101, sections 19.1.1.4.1 and 8.2.3.2. The deficient practice could affect all 39 residents. Findings include: On facility tour between 8:30 AM and 11:00 AM on 02/28/2013, observation revealed, that the 2-hour rated building separation double doors between Type II and Type V buildings, two out of four doors did not shut and latch This deficient practice was confirmed by Administrator (BS) Director of Environmental	K 011	K011 Both doors were fixed so they automatically shut and latch. Maintenance Director is responsible for correction and monitoring to prevent re-occurrence. Date of completion: April 10, 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245383	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/28/2013

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K 011	Continued From page 3 Services (CR) at the time of discovery.	K 011		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 25 out of 39 residents. Findings include: On facility tour between 8:30 AM and 11:00 AM on 02/28/2013, observation revealed that the following was found: 1. North boiler room - open penetrations on north wall around several conduits 2. Soiled utility room # 341 has a 3 ft x 3 ft opening in the west wall 3. 300 wing storage room - west door does not	K 029	K029 1. North Boiler Room – open penetrations around conduits were fire caulked. 2. Soiled Utility Room #341 – glass board was placed to cover the opening in the wall. 3. 300 Wing Storage Room – self-closing hinges were tightened so the door will automatically shut and latch. 4. 100 Wing Soiled Utility Room – door knob was tightened so door will automatically shut and latch. 5. Hazardous Waste Room in the 100 Wing – installed 2 self closing hinges and a door closure so the door will automatically shut and latch. Maintenance Director is responsible for correction and monitoring to prevent re-occurrence. Date of completion: April 10, 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245383	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/28/2013

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K 029	Continued From page 4 have a automatic closer on door 4. 100 wing soiled utility room will not shut and latch 5. Hazardous waste room in the 100 wing will not shut and latch These deficient practices were confirmed by Administrator (BS) Director of Environmental Services (CR) at the time of discovery.	K 029		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed maintain the fire alarm system in accordance with the requirement 1999 NFPA 72, Section 7-3.2.1. The deficient practice could affect all 39 residents. Findings include: On facility tour between 8:30 AM and 11:00 AM on 02/28/2013, the review of the annual fire alarm system inspection / test was not completed in a 12 month period. The report from Custom Alarm indicated the 2012 was completed on 10/22/2012 and 2011 was completed on 10/03/2011. This deficient practice was confirmed by Administrator (BS) Director of Environmental Services (CR) at the time of discovery.	K 054	K054 The annual fire alarm system inspection/test was completed on 10/22/12. The alarm company has been contacted and this year's inspection will be completed before 10/21/13. Maintenance Director is responsible for correction and monitoring to prevent re-occurrence. Date of completion: April 10, 2013	

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
	245383	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/28/2013

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K 054	Continued From page 5 *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 054		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245383	A. BUILDING 02 - 1992 ADDITION B. WING _____	02/28/2013

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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. At the time of this survey, Owatonna Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	POC ok TS 4-2-13	

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

Administrator 3/28/13

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
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K 000	Continued From page 1 By email to: Barbara.Lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility will be surveyed as two separate buildings. Owatonna Commons Nursing & Rehab, 1992 addition is a 1-story building with no basement. The 1992 addition was determined to be of Type V (111) construction. The 1992 addition building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 55 beds and had a census of 39 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 011		

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K 011	Continued From page 2 If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide 2-hour rated construction at the building separation walls in accordance with 2000 - NFPA 101, sections 19.1.1.4.1 and 8.2.3.2. The deficient practice could affect all 39 residents. Findings include: On facility tour between 8:30 AM and 11:00 AM on 02/28/2013, observation revealed, that the 2-hour rated building separation double doors between Type II and Type V buildings, two out of four doors did not shut and latch This deficient practice was confirmed by Administrator (BS) Director of Environmental Services (CR) at the time of discovery.	K 011	K011 Both doors were fixed so they automatically shut and latch. Maintenance Director is responsible for correction and monitoring to prevent re-occurrence. Date of completion: April 10, 2013	
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3	K 054		

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K 054	Continued From page 3 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed maintain the fire alarm system in accordance with the requirement 1999 NFPA 72, Section 7-3.2.1. The deficient practice could affect all 39 residents. Findings include: On facility tour between 8:30 AM and 11:00 AM on 02/28/2013, the review of the annual fire alarm system inspection / test was not completed in a 12 month period. The report from Custom Alarm indicated the 2012 was completed on 10/22/2012 and 2011 was completed on 10/03/2011. This deficient practice was confirmed by Administrator (BS) Director of Environmental Services (CR) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 054	K054 The annual fire alarm system inspection/test was completed on 10/22/12. The alarm company has been contacted and this year's inspection will be completed before 10/21/13. Maintenance Director is responsible for correction and monitoring to prevent re-occurrence. Date of completion: April 10, 2013	