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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: ITG3
Facility ID: 00636

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245253**

2. STATE VENDOR OR MEDICAID NO.
(L2) **907455000**

3. NAME AND ADDRESS OF FACILITY
(L3) **CENTRACARE HEALTH PAYNESVILLE KORONIS MANOR CC**
(L4) **200 FIRST STREET WEST**
(L5) **PAYNESVILLE, MN** (L6) **56362**

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) **10/01/2013**

6. DATE OF SURVEY **04/04/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12. Total Facility Beds **51** (L18)

13. Total Certified Beds **51** (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	51			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Brenda Fischer, Unit Supervisor 04/04/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 05/03/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
09/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00000
(L31)

30. REMARKS
Posted 06/27/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/29/2017
(L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245253
May 3, 2017

Mr. Jason Carlson, Administrator
Centracare Health Paynesville Koronis Manor Care Center
200 First Street West
Paynesville, MN 56362

Dear Mr. Carlson:

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

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

Effective March 20, 2017 the above facility is certified for or recommended for:

110 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 110 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 28, 2017

Mr. Jason Carlson, Administrator
Centracare Health Paynesville Koronis Manor Care Center
200 First Street West
Paynesville, MN 56362

RE: Project Number S5200027

Dear Mr. Carlson:

On March 2, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 15, 2017. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On April 4, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on April 10, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 15, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 20, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 15, 2017, effective March 20, 2017 and therefore remedies outlined in our letter to you dated March 2, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

An equal opportunity employer.

Sincerely,

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

cc: Licensing and Certification File

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245253		4/4/2017

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH PAYNESVILLE KORONIS MANOR CC	200 FIRST STREET WEST PAYNESVILLE, MN 56362

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0441 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 03/20/2017	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	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) BF/KJ	DATE 05/03/2017	SIGNATURE OF SURVEYOR 10562	DATE 04/04/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/15/2017	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0460 0003 5695 6849

May 1, 2017

Mr. Brandon Pietsch, Administrator
Frank Carter, Building Manager
Centracare Health Paynesville Koronis Manor Care Center
200 First Street West
Paynesville, MN 56362

Subject: Centracare Health Paynesville Koronis Manor CC - IDR
Provider # 245253 HFID 00636
Project # F5253026

Dear Mr. Pietsch:

On March 17, 2017, the Minnesota Department of Health (MDH) received a request from your facility for an informal dispute resolution (IDR). This IDR request identified Data Tag K754. On February 14, 2017, the State Fire Marshal cited this deficiency during a recertification survey. Your facility is contesting the validity of tag K754; your letter suggests that the containers are located in a room protected as hazardous and the facility is therefore in compliance with the code.

I have reviewed the information submitted with your request. Also, I spoke with the surveyor who cited this deficiency. The following has been determined:

K754: S/S = D, Soiled Linen and Trash Containers

The regulation requires - in part - that soiled linen receptacles shall not exceed 32 gallons in capacity and the average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A deficiency was cited because soiled linen receptacles exceeded 32 gallons in a soiled linen room. National Fire Protection Association (NFPA) 101 (Life Safety Code, 2012 edition), Chapter 19, Section 19.7.5.7.1 limits soiled linen receptacles to 32 gallons and compliance with four other requirements:

1. The average density of container capacity in a room or space shall not exceed 0.5 gal/square feet.
2. A capacity of 32 gallons shall not be exceeded within any 64 square foot area.
3. Mobile soiled linen with capacities greater than 32 gallons shall be located a room protected as hazardous when not attended.
4. Container size shall not be limited in hazardous areas.

The soiled linen receptacles located in the room cited were greater than 32 gallons and therefore must be located in a room protected as a hazardous area as indicated in number 4 above. NFPA 101, 19.3.2.1 states that any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with section 8.7.1. Section 8.7.1 requires the automatic sprinkler extinguishing system to be in accordance with section 9.7. Section 9.7 requires this facility to have an automatic sprinkler system to be in accordance with NFPA 13.

The facility was not cited for any deficiencies related to compliance with NFPA 13 on this survey. I also spoke with the surveyor and they agreed that the facility appeared to have a compliant automatic sprinkler system in the facility and that particular room.

I believe that this arrangement complies with the requirement of NFPA 101, Chapter 19, 19.7.5.7.1 because the room contains soiled linen containers in excess of the stated 32 gallons **but the room is protected as a hazardous space as required by 19.3.2.1.**

I believe the deficiency should be removed from the Form CMS 2567 (Statement of Deficiencies).

This concludes the Minnesota Department of Health informal dispute resolution process. Please note it is your responsibility to share the information contained in this letter and the results of this review with the President of your facility's Governing Body.

The revised Statement of Deficiencies is attached.

If you have any further questions regarding this matter, please contact me.

Sincerely,

Bob Dehler, P.E.
Engineering Program Manager, Health Regulation Division
Minnesota Department of Health
PO Box 64900,
St. Paul, MN 55164-0900
651 201-3710
robert.dehler@state.mn.us
http://www.health.state.mn.us/divs/fpc/engineering

cc: Office of Ombudsman for Long-Term Care
Tom Linhoff, Fire Safety Supervisor
Pam Kerssen, Assistant Program Manager
Electronic file copy

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
	245253	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______________	**02/14/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH PAYNESVILLE KORONIS MANOR CC	**200 FIRST STREET WEST** **PAYNESVILLE, MN 56362**

(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	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Paynesville Area Health Care System - Koronis Manor 01 Main Building was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/08/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245253	A. BUILDING **01 - MAIN BUILDING 01** B. WING ___	**02/14/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH PAYNESVILLE KORONIS MANOR CC	**200 FIRST STREET WEST** **PAYNESVILLE, MN 56362**

(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	K 000		

By email to:
Marian.Whitney@state.mn.us and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

The Paynesville Area Health Care System - Koronis Manor was constructed at 4 different times. The original building was constructed in 1965, is 1-story and was determined to be of Type II(000) construction. In 1969 an addition was added to the main building, Type II (000) no basement. In 1989 a 1-story addition with no basement was constructed and was determined to be of Type II(000). In 2000 a Southwest addition was added with partial basement housing only mechanical equipment. Type V (111) The building is divided into 3 smoke compartments by 30 minute and 2-hour fire barriers.

Fully sprinkler protected with a manual fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification.

The building is fully sprinkler protected and has a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245253	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**02/14/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH PAYNESVILLE KORONIS MANOR CC	**200 FIRST STREET WEST** **PAYNESVILLE, MN 56362**

(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 2 manual fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 52 beds and had a census of 46 at the time of the survey. Because the original building and the addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: ITG3
Facility ID: 00636

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245253**

2. STATE VENDOR OR MEDICAID NO. (L2) **907455000**

3. NAME AND ADDRESS OF FACILITY
(L3) **CENTRACARE HEALTH PAYNESVILLE KORONIS MANOR CC**
(L4) **200 FIRST STREET WEST**
(L5) **PAYNESVILLE, MN** (L6) **56362**

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) **10/01/2013**

6. DATE OF SURVEY **02/15/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **51** (L18)

13.Total Certified Beds **51** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With
Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

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

* Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	51			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Mardelle Trettel, HFE NE II 03/22/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 03/28/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **09/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00000** (L31)

30. REMARKS

Posted 03/29/2017 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 2, 2017

Mr. Jason Carlson, Administrator
Centracare Health Paynesville Koronis Manor Care Center
200 First Street West
Paynesville, MN 56362

RE: Project Number S5253027

Dear Mr. Carlson:

On February 15, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing & Certification
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 27, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 27, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 15, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 15, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

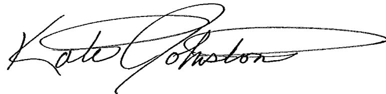
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those

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

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

Feel free to contact me if you have questions.

Sincerely,



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

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245253	A. BUILDING ______ B. WING ______	02/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH PAYNESVILLE KORONIS MANOR CC	**200 FIRST STREET WEST** **PAYNESVILLE, MN 56362**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 2/12/17 to 2/15/17, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). CentraCare Health - Paynesville was found to not be in compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment	F 441		3/20/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/08/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245253	A. BUILDING ______ B. WING ______	02/15/2017

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F 441	Continued From page 1 implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CENTRACARE HEALTH PAYNESVILLE KORONIS MANOR CC	**200 FIRST STREET WEST PAYNESVILLE, MN 56362**

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F 441	Continued From page 2 under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement a comprehensive infection control program to include analysis of collected data to prevent potential spread of infection in the facility. This had potential to affect all 46 residents, staff and visitors in the facility. Findings include: The facility collected infection control data for each month was provided by registered nurse (RN)-A on 2/13/17, and identified the following information: NOVEMBER 2016: A Monthly Report of Resident Infections in Facility listing dated 11/2016, identified five different residents had infections, with two urinary tract infections (UTI), three lower respiratory (LR) and one ophthalmic infection being identified. The flowsheet identified each infection' date of start, site, antibiotic treatment, and corresponding cultures (if obtained). Further, the listing identified four of the infections were facility acquired, and two were community acquired.	F 441	F441—INFECTION CONTROL, PREVENT SPREAD, LINENS -Corrective action for those residents found to have been affected by the deficient practice: No residents were specifically identified to have been affected by the deficient practice. -Identification of other residents having the potential to be affected by the deficient practice: All residents have the potential to be affected by the deficient practice. -Measures to be put in place or systemic changes made to ensure that the deficient practice will not recur: The Director of Nursing and Infection Prevention Nurse reviewed the facility's policy and procedures for monitoring, tracking, trending and analyzing infections treated within the facility. The policy was revised to include enhanced guidance regarding trending, analyzing and implementing appropriate action related to infections. -Facility monitoring of performance to make sure that solutions are maintained:	

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F 441	Continued From page 3 An undated Koronis Manor Care Center Resident Infections 2016 graph was provided. The graph was color coded with several categories of infections including upper respiratory, lower respiratory, skin/wound, gastrointestinal (GI) and ear. The graph listed October 2016 and November 2016 data, however lacked any documented analysis of the collected data to determine if infections were spreading, or if any action plans needed to be developed to address the identified infections. No further information was provided to demonstrate any analysis of the collected data had been completed to determine if the identified infections were related and/or spreading; or if any action plans had been identified or implemented to address them. DECEMBER 2016: A Monthly Report of Resident Infections in Facility listing dated 12/2016, identified nine different residents had infections, with six UTI, one LR, one cellulitis and one being listed, "Unknown." The flowsheet identified each infection' date of start, site, antibiotic treatment, and corresponding cultures (if obtained) along with six of the infections being facility acquired, and two being community acquired. Further, the listing identified two of the UTIs were resulted from the same organism, Proteus Mirabilis (bacteria commonly seen in UTI's), between two different residents on the same unit (North). An undated Koronis Manor Care Center Resident Infections 2016 graph was provided. The graph was color coded with several categories of infections including upper respiratory, lower	F 441	A monthly audit of the facility infection control data summary will be completed by the Director of Nursing for a period of six months to verify that analysis of collected data has been completed to prevent the potential spread of infection in the facility. The audit results will be presented to the facility Quality Assurance Committee for a period of six months to assure that compliance has been attained.	

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	245253	A. BUILDING ______ B. WING ______	02/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH PAYNESVILLE KORONIS MANOR CC	**200 FIRST STREET WEST PAYNESVILLE, MN 56362**

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F 441	Continued From page 4	F 441		

respiratory, skin/wound, GI and ear. The graph listed October 2016, November 2016 and December 2016 data, however lacked any documented analysis of the collected data to determine if infections were spreading, or if any action plans needed to be developed to address the identified infections.

A Infection Control Report dated 12/2016, identified the facility had six, "Facility acquired," infections with five being UTI related, and one cellulitis. The report listed two community acquired infections including one UTI and one LR. Further, the report identified 16 episodes of employee illnesses and added, "Employee illnesses and resident illnesses are not found to be in correlation with each other."

No further information was provided to demonstrate any analysis of the collected data had been completed to determine if the identified infections were related and/or spreading, or if any action plans had been identified or implemented to address them.

JANUARY 2017:

A Monthly Report of Resident Infections in Facility listing dated 1/2017, identified 15 different residents had infections, with one UTI, five LR, two fungal, two ophthalmic, and one cellulitis. The flowsheet identified each infection' date of start, site, antibiotic treatment, and corresponding cultures (if obtained) along with 13 of the infections being facility acquired, and three being community acquired. Further, the listing identified one resident had tested positive for Influenza B.

An undated Koronis Manor Care Center Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245253	A. BUILDING ______ B. WING ______	02/15/2017

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CENTRACARE HEALTH PAYNESVILLE KORONIS MANOR CC	200 FIRST STREET WEST PAYNESVILLE, MN 56362

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F 441	Continued From page 5	F 441		

Infections 2017 graph was provided. The graph was color coded with several categories of infections including upper respiratory, lower respiratory, skin/wound, GI and ear. The graph listed October 2016, November 2016, December 2016 and January 2017 data, however lacked any documented analysis of the collected data to determine if infections were spreading, or if any action plans needed to be developed to address the identified infections.

A Infection Control Report dated 1/2017, identified the facility had 13, "Facility acquired," infections with five being LR, one UTI, three skin/wound, one ophthalmic, one vaginal and two being classified as, "Other." The report listed three community acquired infections including one ophthalmic and two LR. Further, the report identified 28 episodes of employee illnesses and added, "Employee illnesses and resident illnesses are not found to be in correlation with each other."

A Koronis Manor Care Center Resident Infection Report 2017 dated 10/2016 to 1/2017, identified four columns with each month being listed. The infection, "Incidence Rate[s]," were identified as follows:

October 2016 - 2.67% (percent),
November 2016 - 2.82% and,
December 2016 - 4.32% and,
January 2017 - 9.33%.

No further information was provided to demonstrate any analysis of the collected data had been completed to determine if the identified infections were related and/or spreading, or if any action plans had been identified or implemented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245253	A. BUILDING ______ B. WING ______	02/15/2017

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F 441	Continued From page 6 to address the increasing infection incidence rate for the facility. When interviewed on 2/15/17, at 10:01 a.m. RN-A stated she was in charge of the infection control program and had been overseeing it for the past, "Year and a half approximately." RN-A stated she gathered infection data by reviewing progress notes and consulting with the floor staff, then tracked them on the provided listings. At months end, RN-A then enters the collected data onto a spreadsheet and creates the provided reports containing the data. RN-A stated these reports are then presented at the infection control and quality assurance meetings. RN-A stated there had been no documented analysis of the collected data to determine in the identified infections were related or spreading, nor had any action plans been developed to address the increasing infection incidence rate identified on the reports. A facility Infection Prevention and Control Program policy dated 2/2017, identified the infection control program was used to, "Decrease the risk of infection to residents and personnel, monitor for occurrence of infection, implement appropriate control measures, identify and correct problems relating to infection prevention practices, and maintain compliance with state and federal regulations relating to infection prevention." Further, the policy directed staff to complete on-going monitoring of infections amongst residents and employees and document record of community acquired and health-care associated infections. The policy did not identify any steps to ensure the collected data was routinely reviewed and	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245253	A. BUILDING ______ B. WING ______	**02/15/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH PAYNESVILLE KORONIS MANOR CC	**200 FIRST STREET WEST PAYNESVILLE, MN 56362**

(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 441	Continued From page 7 analyzed to determine if infections were spreading, or if any action plans needed to be developed to address the identified infections.	F 441		

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted
March 2, 2017

Mr. Jason Carlson, Administrator
Centracare Health Paynesville Koronis Manor Care Center
200 First Street West
Paynesville, MN 56362

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5253027

Dear Mr. Carlson:

The above facility was surveyed on February 12, 2017 through February 15, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

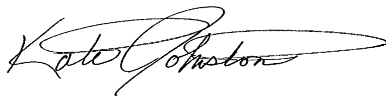
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,



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

Enclosure(s)
cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00636	A. BUILDING: _____ B. WING _____	02/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH PAYNESVILLE KORONIS MAI	**200 FIRST STREET WEST PAYNESVILLE, MN 56362**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00636	A. BUILDING: ______ B. WING ______	02/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH PAYNESVILLE KORONIS MAI	**200 FIRST STREET WEST PAYNESVILLE, MN 56362**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.

On 2/12/17 to 2/15/17, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.

Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.

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

THERE IS NO REQUIREMENT TO SUBMIT A

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2 000	Continued From page 2 PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement a comprehensive	21390		

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infection control program to include analysis of collected data to prevent potential spread of infection in the facility. This had potential to affect all 46 residents, staff and visitors in the facility.

Findings include:

The facility collected infection control data for each month was provided by registered nurse (RN)-A on 2/13/17, and identified the following information:

NOVEMBER 2016:

A Monthly Report of Resident Infections in Facility listing dated 11/2016, identified five different residents had infections, with two urinary tract infections (UTI), three lower respiratory (LR) and one ophthalmic infection being identified. The flowsheet identified each infection' date of start, site, antibiotic treatment, and corresponding cultures (if obtained). Further, the listing identified four of the infections were facility acquired, and two were community acquired.

An undated Koronis Manor Care Center Resident Infections 2016 graph was provided. The graph was color coded with several categories of infections including upper respiratory, lower respiratory, skin/wound, gastrointestinal (GI) and ear. The graph listed October 2016 and November 2016 data, however lacked any documented analysis of the collected data to determine if infections were spreading, or if any action plans needed to be developed to address the identified infections.

No further information was provided to demonstrate any analysis of the collected data had been completed to determine if the identified

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infections were related and/or spreading; or if any action plans had been identified or implemented to address them.

DECEMBER 2016:

A Monthly Report of Resident Infections in Facility listing dated 12/2016, identified nine different residents had infections, with six UTI, one LR, one cellulitis and one being listed, "Unknown." The flowsheet identified each infection' date of start, site, antibiotic treatment, and corresponding cultures (if obtained) along with six of the infections being facility acquired, and two being community acquired. Further, the listing identified two of the UTIs were resulted from the same organism, Proteus Mirabilis (bacteria commonly seen in UTI's), between two different residents on the same unit (North).

An undated Koronis Manor Care Center Resident Infections 2016 graph was provided. The graph was color coded with several categories of infections including upper respiratory, lower respiratory, skin/wound, GI and ear. The graph listed October 2016, November 2016 and December 2016 data, however lacked any documented analysis of the collected data to determine if infections were spreading, or if any action plans needed to be developed to address the identified infections.

A Infection Control Report dated 12/2016, identified the facility had six, "Facility acquired," infections with five being UTI related, and one cellulitis. The report listed two community acquired infections including one UTI and one LR. Further, the report identified 16 episodes of employee illnesses and added, "Employee illnesses and resident illnesses are not found to

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be in correlation with each other."

No further information was provided to demonstrate any analysis of the collected data had been completed to determine if the identified infections were related and/or spreading, or if any action plans had been identified or implemented to address them.

JANUARY 2017:

A Monthly Report of Resident Infections in Facility listing dated 1/2017, identified 15 different residents had infections, with one UTI, five LR, two fungal, two ophthalmic, and one cellulitis. The flowsheet identified each infection' date of start, site, antibiotic treatment, and corresponding cultures (if obtained) along with 13 of the infections being facility acquired, and three being community acquired. Further, the listing identified one resident had tested positive for Influenza B.

An undated Koronis Manor Care Center Resident Infections 2017 graph was provided. The graph was color coded with several categories of infections including upper respiratory, lower respiratory, skin/wound, GI and ear. The graph listed October 2016, November 2016, December 2016 and January 2017 data, however lacked any documented analysis of the collected data to determine if infections were spreading, or if any action plans needed to be developed to address the identified infections.

A Infection Control Report dated 1/2017, identified the facility had 13, "Facility acquired," infections with five being LR, one UTI, three skin/wound, one ophthalmic, one vaginal and two being classified as, "Other." The report listed three community acquired infections including

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one ophthalmic and two LR. Further, the report identified 28 episodes of employee illnesses and added, "Employee illnesses and resident illnesses are not found to be in correlation with each other."

A Koronis Manor Care Center Resident Infection Report 2017 dated 10/2016 to 1/2017, identified four columns with each month being listed. The infection, "Incidence Rate[s]," were identified as follows:

October 2016 - 2.67% (percent),
November 2016 - 2.82% and,
December 2016 - 4.32% and,
January 2017 - 9.33%.

No further information was provided to demonstrate any analysis of the collected data had been completed to determine if the identified infections were related and/or spreading, or if any action plans had been identified or implemented to address the increasing infection incidence rate for the facility.

When interviewed on 2/15/17, at 10:01 a.m. RN-A stated she was in charge of the infection control program and had been overseeing it for the past, "Year and a half approximately." RN-A stated she gathered infection data by reviewing progress notes and consulting with the floor staff, then tracked them on the provided listings. At months end, RN-A then enters the collected data onto a spreadsheet and creates the provided reports containing the data. RN-A stated these reports are then presented at the infection control and quality assurance meetings. RN-A stated there had been no documented analysis of the collected data to determine in the identified infections were related or spreading, nor had any

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action plans been developed to address the increasing infection incidence rate identified on the reports.

A facility Infection Prevention and Control Program policy dated 2/2017, identified the infection control program was used to, "Decrease the risk of infection to residents and personnel, monitor for occurrence of infection, implement appropriate control measures, identify and correct problems relating to infection prevention practices, and maintain compliance with state and federal regulations relating to infection prevention." Further, the policy directed staff to complete on-going monitoring of infections amongst residents and employees and document record of community acquired and health-care associated infections.

The policy did not identify any steps to ensure the collected data was routinely reviewed and analyzed to determine if infections were spreading, or if any action plans needed to be developed to address the identified infections.

SUGGESTED METHOD OF CORRECTION:
The director of nursing and/or their designee could review the facility's policy and procedures for monitoring, tracking, trending and analyzing infections treated within the facility. She could then monitor this on a regular basis to ensure compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.