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: J6VB
Facility ID: 00725

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245243**
2.STATE VENDOR OR MEDICAID NO.
(L2) **375340900**

3. NAME AND ADDRESS OF FACILITY
(L3) **MUNICIPAL HOSP & GRANITE MANOR**
(L4) **345 TENTH AVENUE**
(L5) **GRANITE FALLS, MN** (L6) **56241**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)
6. DATE OF SURVEY **11/25/2014** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :
12.Total Facility Beds **57** (L18)
13.Total Certified Beds **57** (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
	57			
(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 :
Jodi Johnson, HFE NEII 12/10/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 12/10/2014 (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
07/06/1981
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/24/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245243

December 10, 2014

Mr. George Gerlach, Administrator
Municipal Hospital & Granite Manor
345 Tenth Avenue
Granite Falls, Minnesota 56241

Dear Mr. Gerlach:

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 November 13, 2014 the above facility is certified for:

57 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 57 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, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

December 10, 2014

Mr. George Gerlach, Administrator
Municipal Hospital & Granite Manor
345 Tenth Avenue
Granite Falls, Minnesota 56241

RE: Project Number S5243025

Dear Mr. Gerlach:

On October 27, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 16, 2014 . 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 November 25, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on November 24, 2014 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 October 16, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 13, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 16, 2014, effective November 13, 2014 and therefore remedies outlined in our letter to you dated October 27, 2014, 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, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File 5243r15

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
245243	A. Building B. Wing	11/25/2014

Name of Facility	Street Address, City, State, Zip Code
MUNICIPAL HOSP & GRANITE MANOR	345 TENTH AVENUE GRANITE FALLS, MN 56241

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 **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	**11/13/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**11/04/2014**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	**11/04/2014**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	**11/13/2014**	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 State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SR/mm	12/10/2014	33564	11/25/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 10/16/2014

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 A. Building B. Wing	(Y3) Date of Revisit
245243	01 - MAIN BUILDING 01	11/24/2014

Name of Facility	Street Address, City, State, Zip Code
MUNICIPAL HOSP & GRANITE MANOR	345 TENTH AVENUE GRANITE FALLS, MN 56241

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 K0144	10/31/2014	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		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/mm	12/10/2014	19251	11/24/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 10/15/2014

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

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: J6VB
Facility ID: 00725

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245243**

2. STATE VENDOR OR MEDICAID NO. (L2) **375340900**

3. NAME AND ADDRESS OF FACILITY
(L3) **MUNICIPAL HOSP & GRANITE MANOR**
(L4) **345 TENTH AVENUE**
(L5) **GRANITE FALLS, MN** (L6) **56241**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **10/16/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

12. Total Facility Beds **57** (L18)

13. Total Certified Beds **57** (L17)

10. THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	57			
(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
Robyn Woolley, HFE NE II
Date : 11/13/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL
Anne Kleppe, Enforcement Specialist
Date: 11/19/2014 (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
07/06/1981
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 4905

October 27, 2014

Mr. George Gerlach, Administrator
Municipal Hospital & Granite Manor
345 Tenth Avenue
Granite Falls, Minnesota 56241

RE: Project Number S5243025

Dear Mr. Gerlach:

On October 16, 2014, 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;**
>
> **<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**
>
> **<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.**

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: susanne.reuss@state.mn.us
Telephone: (651) 201-3793
Fax: (651) 201-3790

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 November 25, 2014, 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 November 25, 2014 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 January 16, 2015 (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 April 16, 2015 (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 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124   Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

PRINTED: 10/27/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245243	A. BUILDING ______ B. WING ______	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MUNICIPAL HOSP & GRANITE MANOR	**345 TENTH AVENUE GRANITE FALLS, MN 56241**

(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	RECEIVED NOV - 7 2014 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed 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	F 280 11/13/14 SER	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP Resident #62 care plan has been adjusted to include specific interventions to use to maintain his physical, safety, and psycho social well being, this update was completed on 10/30/14 by the Quality Assurance RN. All nursing staff were provided with a guide "code sheet" to use as an additional tool to assist with identifying specific behaviors, interventions, and side effects on 10/28/14. Included in this education was specific direction to try all non pharm logical interventions	11-13-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator/CEO (X6) DATE: 11/4/14

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
	245243	A. BUILDING ______ B. WING ______	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MUNICIPAL HOSP & GRANITE MANOR	345 TENTH AVENUE GRANITE FALLS, MN 56241

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F 280	Continued From page 1 by: Based on observation, interview, and document review, the facility failed to ensure resident specific non-drug interventions for mood and behavior were incorporated into the care plan for 1 of 5 residents (R62) reviewed for unnecessary medications. Findings include: On 10/15/14 between 8:18 a.m. and 10:10 a.m., R62 was observed eating breakfast, walking with nursing staff, participating in restorative exercises, watching tv, and visiting with family and surveyor. R62 was also observed periodically during survey days 10/14/14 and 10/16/14 doing similar activities. R62 was calm, displayed no behaviors that put himself or others at significant risk, and was able to talk casually about his interests and his cares. Review of R62's admission and quarterly minimum data set [MDS], dated 7/7/14 and 9/25/14, revealed R62 was significantly cognitively impaired, and displayed no disruptive behaviors that had a significant impact on himself or others. Review of R62's care area assessments, dated 7/7/14, revealed R62 had diagnoses of dementia and a recent hip fracture with repair related to a fall. He had a long history of tobacco use, oxygen dependence, and depression. The goal of family and resident was for R62 to be happy. The care area assessments did not address behaviors that had a serious risk of harm to R62 or others. A review of the care plan, last revised 10/3/14 revealed, "Potential for acute behavioral change	F 280	prior to utilizing any PRN medications. Additionally any of the residents who had been utilizing any PRN anti-anxiety medications over the last 2 weeks were assessed for appropriate pain management. This will be monitored quarterly and as needed with a goal to reduce or eliminate those types of medications. Two of these residents have new orders for scheduled Tylenol to help prevent behaviors associated with pain. The DON will monitor for use of any anti-anxiety, anti-psychotic medications monthly. This will also be a focus of our pharmacy consultant that reviews and audits medications monthly. The physicians will be updated regarding the survey and our goals to eliminate use of anti-anxiety and anti-psychotic medications at the "Medical Staff Meeting" on November 6, 2014 by the Director of Nursing. Resident #62	

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F 280	Continued From page 2 related to dementia and new environment as evidenced by increased level of confusion" The goal was "Will not present a threat to others." Interventions included "Re-direction, Medication Management, Activity of choice, 1:1 visit, Offer snacks, Refer to SW" and "Assess for causal factors. Identify that behavioral changes are typically unmet needs. Monitor for interventions that assist to reduce outbursts and pass this information on to other care providers. Asses for pain. Update physician as needed." The interventions were not specific to R62. Medication administration history for October 2014 revealed the following scheduled prescription medications for R62: lorazepam 0.5 milligrams (mg) once an evening (anti-anxiety) , divalproex extended release 250 mg twice daily (mood stabilizer), paroxetine HCL 30mg once a morning (anti-depressant). As needed (prn) medications included: haloperidol 0.5 mg every hour prn with directions "Use Ativan first. For agitation that causes undue distress to self and/or danger to self and other and is unrelieved by Ativan (lorazepam)", hydroxyzine pamoate 25 mg every 4 hours prn (anti-anxiety), and lorazepam 0.5 mg every 2 hours prn (anti-anxiety). A review of the October medication administration records revealed R62 received the following prn doses: Lorazepam 0.5 mg prn on 5 days and a total of 7 doses, haloperidol 0.5 mg on 3 days and a total of 5 doses and hydroxyzine pamoate 25 mg on 4 days and a total of 4 doses. In September R62 received lorazepam 0.5 mg on 14 days and a total of 18 doses, haloperidol 0.5mg on 2 days for a total of 2 doses; haloperidol 1 mg on 1 day for a total of 1 dose and vistaril on 4 days for a total of 4 doses.	F 280	physician was updated on this in the fax request to discontinue his scheduled Ativan dose see below. Residents #62 care plan was adjusted with the new interventions and his physician was updated and a request was sent to discontinue his scheduled 5pm Ativan dose. The DON will consult with the physician at Resident #62's next routine visit [scheduled for December 2014] and we will attempt to discontinue his PRN Ativan dose and PRN Haldol dose. The update was faxed to the physician on 10/31/14 by the Director of Nursing. Resident #62's family has also been updated and will come as available to help redirect and reduce behavior issues that become potentially self-injurious. Additionally a plan was developed with the Activity department to start a new group for those residents who have dementia that have been	

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F 280	Continued From page 3 Review of the daily observation tool, for all of September and October 1st through 15th, revealed R62 demonstrated anxiety on 18 days. On 18 of 18 days R62 received an as needed prescription drug intervention. Interventions options listed were similar to the care plan: 1. Redirection from others for safety. 2. Ativan 1st, Haldol if ineffective 3. Offer snacks he lies 4. Pain control-pharmaceutical and non pharmaceutical 5. Bring to bathroom 6. Activity of choice 7. Talk 1:1. During interview on 10/16/14 at 10:49 a.m., the nurse manager, (RN)-B confirmed findings. RN-B confirmed the interventions could be more specific to R62 including past leisure and vocational interests, history of tobacco use, what food he liked or the most effective manner to redirect him. RN-B was not sure why R62 was prescribed multiple psychoactive medications. During interview on 10/16/14 at 2:52 p.m., the social worker, (LICSW)-A confirmed the care plan was "generic" and R62 saw a therapist regularly at the facility who may be able to assist with developing more resident specific care plan interventions. During interview on 10/16/14 at approximately 4:00 p.m. ,the consultant pharmacist (CP) confirmed he would expect facility staff to incorporate resident specific non-drug interventions into the plan of care.	F 280	exhibiting more behavioral issues every evening after the dinner meal. This will be implemented starting November 17th, 2014. Additional facility interventions: Case Managers have been educated on the importance of detailed, factual behavior documentation on behavior monitoring sheets and in Care Plans. They have been educated on what does and does not constitute a behavior, appropriate interventions and appropriate data evaluations for continuing or revising the residents' plan of care. Case Managers-and all nursing staff-have been educated on the need to use Psychotropic drugs as a last choice and only to allow for the resident's Continued on Page 4a	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in	F 282		

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483.20(d)(3), 483.10(k)(2)
RIGHT TO PARTICIPATE
PLANNING CARE-REVISE CP

highest practicable quality of life. All behavior monitoring sheets have been reviewed and revised as necessary. They have all had added to them to document effect/details in progress notes. All Care Plans have been reviewed and revised as necessary to reflect the non-pharmaceutical interventions listed in the behavior monitoring sheets.

All Manor nursing staff will be attending a 6 hour dementia mandatory education session on either November 11th or 13th, 2014 covering the "Hand in Hand" program from CMS.

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F 282	Continued From page 4 accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, observation and document review, the facility failed to provide services in accordance with the resident's written plan of care for 1 of 3 residents (R16) in the sample who required assistance with ambulation. Findings include: During interview on 10/14/14, at 11:44 a.m. R16 expressed wanting to walk more and the staff did not walk her as often as she would like. R16 was concerned about losing her ability to ambulate in the hallways. R16's Brief Interview for Mental Status (BIMS), dated 6/19/14, indicated a summary score of 15 out of a possible 15 for cognitive patterns, meaning cognitively intact. The plan of care dated 9/25/14, directed staff, "Unsteady balance with transfer and ambulation which indicates the need for a restorative nursing program. New Goal: [R16] will maintain ability to walk with 1 assist and front wheeled walker, 30 feet. Ambulate qid (four times a day) 25-30 feet as tolerated with FWW (front wheeled walker) The physician order dated 7/15/13, read "Ambulate qid 25-30 feet as tolerated with FWW and 2 assist with w/c following behind for safety. QID-Four times a day, AM, Noon, PM, HS [hour of sleep].	F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN Record and staff interview indicate that Resident #16 continues to be non-complaint with her Physician's orders to walk "4" times a day. The Restorative staff LPN interviewed Resident #16 on 10/29/14 and the Resident indicates she is being walked ample times and when offered multiple options that would improve the frequency of her getting a fourth walk completed daily. Resident #16 reports she is getting walked enough. On 10/25/14 she indicated to her physician that the staff was still not walking her enough. Resident #16's care plan was adjusted as she is currently walking 60-100 feet typically three times a day, previous range was 25-30 feet. On 10/28/14 all nursing staff was given education related to the survey deficiencies and the importance of walking the	11-4-14

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F 282	Continued From page 5 During observations on 10/15/14, R16 remained seated in the wheelchair and did not ambulate to meals or in the hallway until 2:05 p.m. Interview with nursing assistant (NA)-B on 10/15/14, at 2:00 p.m. confirmed R16 had not walked and NA-B stated R16 is walked by the restorative aide (RA). At 2:05 p.m. R16 was observed walking with the RA. R16 stated, "This is the first time I have walked today." When interviewed on 10/16/14, at 2:30 p.m. RA stated that ambulation by the RA is to be done above and beyond the ambulation that the NAs are supposed to perform with R16.	F 282	residents as their care plans indicate to maintain or improve their functional status. The staff was instructed to update the pm shift nurse or medication aid if she refuses to walk and they were also instructed to offer a walk right before she gets ready for bed as a last resort if she refused Continued on Page 6a	
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide ambulation to improve or maintain each resident's ability for 1 of 3 residents (R16) reviewed for activities of daily living. Findings include: During the initial interview on 10/14/14, at 11:44 a.m. R16 expressed wanting to walk more and that the staff did not walk her as often as she would like. R16 was concerned about losing her ability to ambulate in the hallways.	F 311		

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483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

to walk during the rest of the shift. Resident #16 is also offered a walk from the Restorative nursing staff daily and they go back if she refuses and offer other time or other exercise options.
An update was faxed to her physician on 10/31/14 requesting that we change her order to "offer walks QID and monitor weekly for compliance and assess functional capacity". The tracking form used to document resident walks will be monitored and audited monthly by the nurse case manager from each unit for all Residents who walk.
The restorative nursing department LPN will also be monitoring quarterly. I also added tracking her QID walks

Continued on Page 6b

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483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

into the electronic medical record so the nurse or medication aid working that unit will have a reminder to make sure that Resident #16 is being offered walks and finding out reasons for any refusals. All Case managers have been educated on the importance of detailed, factual documentation of ambulation during their monthly Restorative Nursing review. They have been educated on the need to correlate the information obtained from the ambulation documentation with their care plan goals and interventions and to adjust and document the goals and interventions to meet the needs of each resident. They

Continued on Page 6c

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483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

have been reminded of the need to always consider individualized, person-centered cares. The Restorative Nursing Department Nurse has made a monthly review table to share at each monthly Restorative Nursing meeting that shows specific details on each resident's restorative nursing orders, level of participation for the last month and specific exercises that the resident is participating in. This review table will be used for review by the monthly Interdisciplinary Restorative Nursing Team as they evaluate each resident's status and individual needs and plan of care. The Restorative Nursing orders that are initiated by the Case Manager are incorporated into the Care Plans. The Ward Clerk will print the Restorative Nursing Monthly Charting Worksheets directly from the Care Plans.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 311	Continued From page 6 During observations on 10/15/14, R16 remained seated in the wheelchair and did not ambulate to meals or in the hallway until 2:05 p.m. Interview with nursing assistant (NA)-B, on 10/15/14, at 2:00 p.m., confirmed R16 had not walked because she is walked by the restorative aide, NA-A. At 2:05 p.m. R16 was observed walking with the NA-A. R16 stated, "This is the first time I have walked today." Interview with NA-A on 10/16/14 at 2:30 p.m. verified that ambulation by the restorative aide is to be done above and beyond the ambulation the nursing assistants are supposed to perform with R16. The active diagnoses from R16's minimum Data Set (MDS) form, dated 6/19/14, included cerebral vascular accident and heart failure. R16's Brief Interview for Mental Status (BIMS), dated 6/19/14, indicated a summary score of 15 out of a possible 15 for cognitive patterns meaning cognitively intact. The plan of care, dated 9/25/14, directed staff, "Unsteady balance with transfer and ambulation which indicates the need for a restorative nursing program. New Goal: [R16] will maintain ability to walk with 1 assist and front wheeled walker, 30 feet. Ambulate qid (four times a day) 25-30 feet as tolerated with FWW (front wheeled walker)." The physician order dated 7/15/13, read "Ambulate qid 25-30 feet as tolerated with FWW and 2 assist with w/c following behind for safety. QID-Four times a day, AM, Noon, PM, HS [hour of sleep]. During review of the various documents, that	F 311	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS Record and staff interview indicate that Resident #16 continues to be non-complaint with her Physician's orders to walk "4" times a day. The Restorative staff LPN interviewed Resident #16 on 10/29/14 and the Resident indicates she is being walked ample times and when offered multiple options that would improve the frequency of her getting a fourth walk completed daily. Resident #16 reports she is getting walked enough. On 10/25/14 she indicated to her physician that the staff was still not walking her enough. Resident #16's care plan was adjusted as she is currently walking 60-100 feet typically three times a day, previous range was 25-30 feet. On 10/28/14 all nursing staff was given education related to the survey deficiencies and the importance of walking the	11-4-14

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F 311	Continued From page 7 verified R16's ambulation, the following was validated with the registered nurses (RN)-A and RN-B: The untitled document which the nursing assistants used to record walking for the month of October 2014, indicated R16 did not walk four times a day, 25 to 30 feet as tolerated on any days in October. Typically the walking was recorded as 10 to 30 feet one to three times a day, when it was recorded. The form titled Point of Care ADL Category Report completed by the nursing assistants each shift of work documented R16 did not ambulate on 10/1/14, 10/2/14, 10/3/14, 10/4/14, 10/6/14, 10/7/14, 10/10/14, 10/12/14, and 10/13/14. During interviews regarding the ambulation documentation discrepancy on 10/16/14, at 11:40 a.m. RN-A and RN-B verified R16 was not ambulated according to the physician order and plan of care to ambulate QID 25-30 feet as tolerated.	F 311	Residents as their care plans indicate to maintain or improve their functional status. The staff was instructed to update the pm shift nurse or medication aid if she refuses to walk and they were also instructed to offer a walk right before she gets ready for bed as a last resort if she refused to walk during the rest of the shift. Resident #16 is also offered a walk from the Restorative nursing staff daily and they go back if she Continued on Page 8a	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug	F 329		

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483.25(a)(2)
TREATMENT/SERVICES TO
IMPROVE/MAINTAIN ADLS

refuses and offer other time or other exercise options.
An update was faxed to her physician on 10/31/14 requesting that we change her order to "offer walks QID and monitor weekly for compliance and assess functional capacity". The tracking form used to document resident walks will be monitored and audited monthly by the nurse case manager from each unit for all Residents who walk. The restorative nursing department LPN will also be monitoring quarterly. I also added tracking her QID walks into the electronic medical record so the nurse or medication aid working that unit will have a reminder to

Continued on Page 8b

483.25(a)
TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS

make sure that Resident #16 is being offered walks and finding out reasons for any refusals. All Case managers have been educated on the importance of detailed, factual documentation of ambulation during their monthly Restorative Nursing review. They have been educated on the need to correlate the information obtained from the ambulation documentation with their care plan goals and interventions and to adjust and document the goals and interventions to meet the needs of each resident. They have been reminded of the need to always consider individualized, person-centered cares.

Continued on Page 8c

Page 8c

483.25(a)
TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS

The Restorative Nursing Department Nurse has made a monthly review table to share at each monthly Restorative Nursing meeting that shows specific details on each resident's restorative nursing orders, level of participation for the last month and specific exercises that the resident is participating in. This review table will be used for review by the monthly Interdisciplinary Restorative Nursing Team as they evaluate each resident's status and individual needs and plan of care.
The Restorative Nursing orders that are initiated by the Case Manager are incorporated into the Care Plans. The Ward Clerk will print the Restorative Nursing Monthly Charting Worksheets directly from the Care Plans.

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F 329	Continued From page 8 therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 5 residents reviewed for unnecessary medications (R62) had a care plan developed with resident specific non-drug interventions to complement or minimize the use of psychotropic medications. Findings include: On 10/15/14 between 8:18 a.m. and 10:10 a.m., R62 was observed eating breakfast, walking with nursing staff, participating in restorative exercises, watching tv, and visiting with family and surveyor. R62 was also observed periodically during survey days 10/14/14 and 10/16/14 doing similar activities. R62 was calm, displayed no behaviors that put himself or others at significant risk, and was able to talk casually about his interests and his cares. Review of R62's admission and quarterly minimum data set [MDS], dated 7/7/14 and 9/25/14, revealed R62 was significantly cognitively impaired, and displayed no disruptive behaviors that had a significant impact on himself	F 329	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Resident #62 care plan has been adjusted to include specific interventions to use to maintain his physical, safety, and psycho social well-being, this update was completed on 10/30/14 by the Quality Assurance RN. All nursing staff was provided with a guide "code sheet" to use as an additional tool to assist with identifying specific behaviors, interventions, and side effects on 10/28/14. Included in this education was specific direction to try all non-pharm logical interventions prior to utilizing any PRN medications. Additionally any of the residents who had been utilizing any PRN anti-anxiety medications over the last 2 weeks, were assessed for appropriate pain management. This will be monitored quarterly and as needed with a goal to reduce or eliminate	11-13-14

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	245243	A. BUILDING ______ B. WING ______	10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MUNICIPAL HOSP & GRANITE MANOR	345 TENTH AVENUE GRANITE FALLS, MN 56241

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F 329	Continued From page 9 or others. Review of R62's care area assessments, dated 7/7/14, revealed R62 had diagnoses of dementia and a recent hip fracture with repair related to a fall. He had a long history of tobacco use, oxygen dependence, and depression. The goal of family and resident was for R62 to be happy. The care area assessments did not address behaviors that had a serious risk of harm to R62 or others. A review of the care plan, last revised 10/3/14 revealed, "Potential for acute behavioral change related to dementia and new environment as evidenced by increased level of confusion" The goal was "Will not present a threat to others." Interventions included "Re-direction, Medication Management, Activity of choice, 1:1 visit, Offer snacks, Refer to SW" and "Assess for causal factors. Identify that behavioral changes are typically unmet needs. Monitor for interventions that assist to reduce outbursts and pass this information on to other care providers. Asses for pain. Update physician as needed." The interventions were not specific to R62. Medication administration history for October 2014 revealed the following scheduled prescription medications for R62: lorazepam 0.5 milligrams (mg) once an evening (anti-anxiety) , divalproex extended release 250 mg twice daily (mood stabilizer), paroxetine HCL 30mg once a morning (anti-depressant). As needed (prn) medications included: haloperidol 0.5 mg every hour prn with directions "Use Ativan first. For agitation that causes undue distress to self and/or danger to self and other and is unrelieved by Ativan (lorazepam)", hydroxyzine pamoate 25 mg every 4 hours prn (anti-anxiety), and lorazepam	F 329	those types of medications. Two of these residents have new orders for scheduled Tylenol to help prevent behaviors associated with pain. The DON will monitor for use of any anti-anxiety, anti-psychotic medications monthly. This will also be a focus of our pharmacy consultant that reviews and audits medications monthly. The physicians will be updated regarding the survey and our goals to eliminate use of anti-anxiety and anti-psychotic medications at the "Medical staff meeting" on November 6, 2014 by the Director of Nursing. Resident #62 physician was updated on this in the fax request to discontinue his scheduled Ativan dose see below. Residents #62 care plan was adjusted with the new interventions and his physician was updated and a request was sent to discontinue his scheduled 5pm Ativan dose.	

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F 329	Continued From page 10 0.5 mg every 2 hours prn (anti-anxiety). A review of the October medication administration records revealed R62 received the following prn doses: Lorazepam 0.5 mg prn on 5 days and a total of 7 doses, haloperidol 0.5 mg on 3 days and a total of 5 doses and hydroxyzine pamoate 25 mg on 4 days and a total of 4 doses. In September R62 received lorazepam 0.5 mg on 14 days and a total of 18 doses, haloperidol 0.5mg on 2 days for a total of 2 doses; haloperidol 1 mg on 1 day for a total of 1 dose and vistaril on 4 days for a total of 4 doses. Review of the daily observation tool, for all of September and October 1st through 15th, revealed R62 demonstrated anxiety on 18 days. On 18 of 18 days R62 received an as needed prescription drug intervention. Interventions options listed were similar to the care plan: 1. Redirection from others for safety. 2. Ativan 1st, Haldol if ineffective 3. Offer snacks he lies 4. Pain control-pharmaceutical and non pharmaceutical 5. Bring to bathroom 6. Activity of choice 7. Talk 1:1. During interview on 10/16/14 at 10:49 a.m., the nurse manager, (RN)-B confirmed findings. RN-B confirmed the interventions could be more specific to R62 including past leisure and vocational interests, history of tobacco use, what food he liked or the most effective manner to redirect him. RN-B was not sure why R62 was prescribed multiple psychoactive medications. During interview on 10/16/14 at 2:52 p.m., the social worker, (LICSW)-A confirmed the care plan was "generic" and R62 saw a therapist regularly at the facility who may be able to assist with developing more resident specific care plan	F 329	The DON will consult with the physician at Resident #62's next routine visit [scheduled for December 2014] and we will attempt to discontinue his PRN Ativan dose and PRN Haldol dose. The update was faxed to the physician on 10/31/14 by the Director of Nursing. Resident #62's family has also been updated and will come as available to help redirect and reduce behavior issues that become potentially self-injurious. Additionally a plan was developed with the Activity department to start a new group for those Residents who have dementia that have been exhibiting more behavioral issues every evening after the dinner meal. This will be implemented starting November 17th, 2014. All Manor nursing staff will be attending a 6 hour dementia mandatory education session on either November 11th or 13th, 2014 covering the "Hand in Hand" program from CMS.	

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F 329	Continued From page 11 interventions. During interview on 10/16/14 at approximately 4:00 p.m. ,the consultant pharmacist (CP) confirmed he would expect facility staff to incorporate resident specific non-drug interventions into the plan of care.	F 329	Additional facility interventions: Case Managers have been educated on the importance of detailed, factual behavior documentation on behavior monitoring sheets and in Care Plans. They have been educated on what does and does not constitute a behavior, appropriate interventions and appropriate data evaluations for continuing or revising the residents' plan of care. Case Managers-and all nursing staff-have been educated on the need to use Psychotropic drugs as a last choice and only to allow for the resident's highest practicable quality of life. All behavior monitoring sheets have been reviewed and revised as necessary. They have all had added to them to document effect/details in progress notes. All Care Plans have been reviewed and revised as necessary to reflect the non-pharmaceutical interventions listed in the behavior monitoring sheets.	

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

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OMB NO. 0938-0391

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	245243	A. BUILDING 01 - MAIN BUILDING 01 B. WING	10/15/2014

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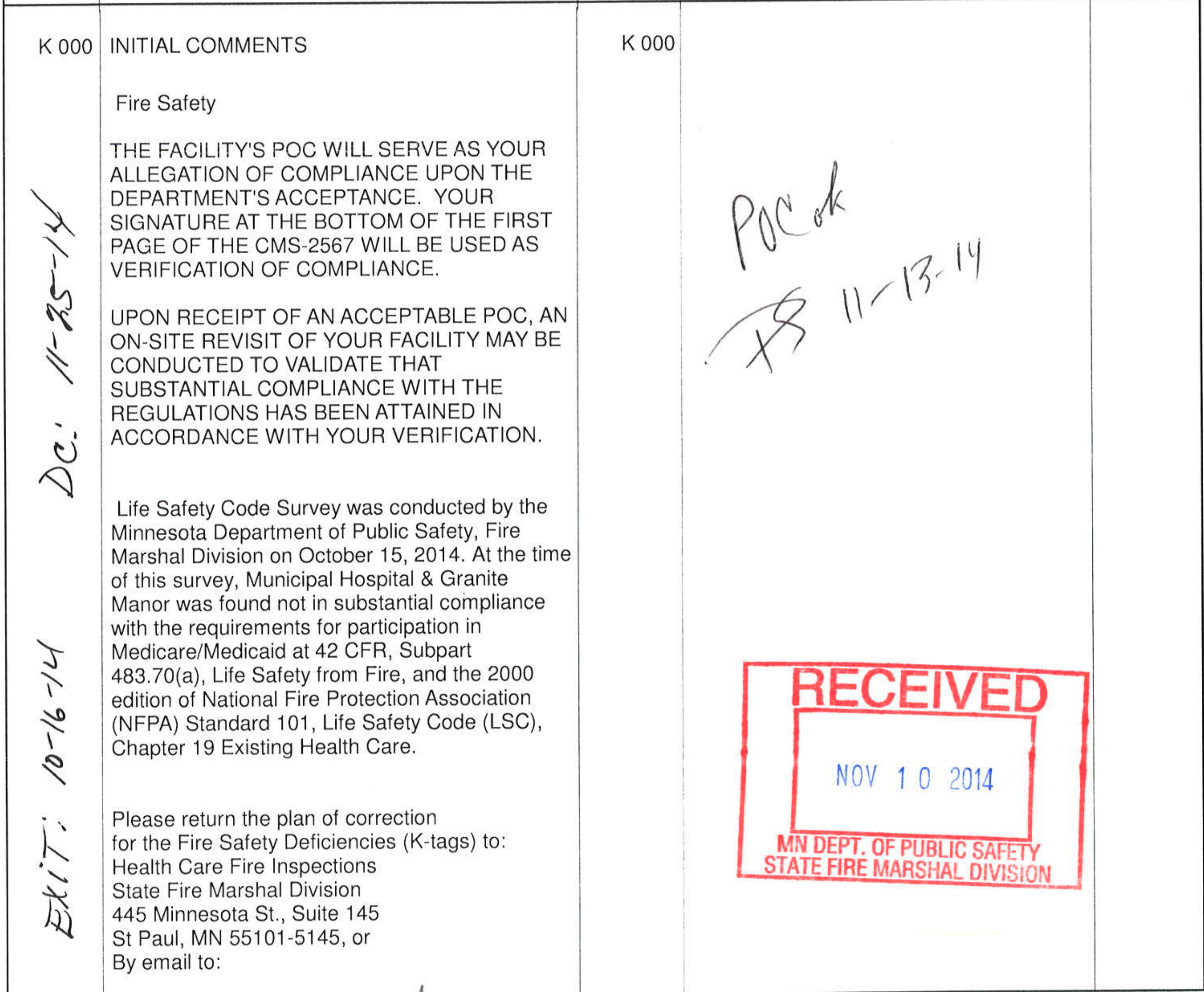
MUNICIPAL HOSP & GRANITE MANOR	345 TENTH AVENUE GRANITE FALLS, MN 56241



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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. Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on October 15, 2014. At the time of this survey, Municipal Hospital & Granite Manor 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 By email to:	K 000	POC ok 11-13-14 RECEIVED NOV 10 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

EXIT: 10-16-14 DC: 11-25-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator/CEO — (X6) DATE: Nov 4, 2014

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

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K 000	Continued From page 1 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. Granite Manor Nursing Home is a 2-story building with full basement. The building was constructed at 2 different times. The original building was constructed in 1947 and was determined to be of Type I(222) construction. In 1960 an addition was constructed and was determined to be of Type I(222) construction. Because the original building and the 1 addition met the construction type allowed for existing buildings, the facility was surveyed as one building. The building is not sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 57 beds and had a census of 43. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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K 144 K 144 SS=F	Continued From page 2 NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on documentation review and interview, the facility has failed to properly document monthly inspections of the emergency generator in accordance with NFPA 99 and NFPA 110. This deficient practice could affect all 43 residents, staff and visitors in the event of a loss of power and generator failure. Findings include: On facility tour between 8:30 AM and 11:30 PM on 10/15/2014, in documentation review and an interview with Maintenance Supervisor, it was revealed that the facility had failed to document all the required information during monthly generator load test in accordance with NFPA 110 (99).	K 144 K 144	K144 NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with the NFPA 99. 3.4.4.1. The maintenance department will properly document all required monthly inspection information of the emergency generator using the State documentation form. The maintenance director is responsible for monitoring the completion of this activity.	10-31-14