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: JP7C
Facility ID: 00568

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245090**

2. STATE VENDOR OR MEDICAID NO.
(L2) **270543500**

3. NAME AND ADDRESS OF FACILITY
(L3) **PLEASANT MANOR INC**
(L4) **27 BRAND AVENUE**
(L5) **FARIBAULT, MN** (L6) **55021**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/21/2015** (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 **65** (L18)

13.Total Certified Beds **65** (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
	65			
(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 :
Gayle Lantto, Supervisor 01/30/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 02/02/2015 (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
01/21/1967
(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
01/12/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5090

Electronically Delivered: February 2, 2015

Mr. Chris Krebsbach, Administrator
Pleasant Manor Inc
27 Brand Avenue
Faribault, Minnesota 55021

Dear Mr. Krebsbach:

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 the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective December 29, 2014 the above facility is certified for or recommended for:

65 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 65 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 about this electronic notice.

Sincerely,

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

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: January 30, 2015

Mr. Chris Krebsbach, Administrator
Pleasant Manor Inc
27 Brand Avenue
Faribault, Minnesota 55021

RE: Project Number S5090024

Dear Mr. Krebsbach:

On December 17, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 4, 2014. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On January 21, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 4, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 29, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 4, 2014, effective December 29, 2014 and therefore remedies outlined in our letter to you dated December 17, 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. Feel free to contact me if you have questions about this electronic notice.

Sincerely,

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

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
245090	A. Building B. Wing	1/21/2015

Name of Facility	Street Address, City, State, Zip Code
PLEASANT MANOR INC	27 BRAND AVENUE FARIBAULT, MN 55021

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 **F0221** Reg. # **483.13(a)** LSC	**12/29/2014**	ID Prefix **F0257** Reg. # **483.15(h)(6)** LSC	**12/29/2014**	ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	**12/29/2014**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**12/29/2014**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	**12/29/2014**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	**12/29/2014**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	**12/29/2014**	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	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GL/AK	01/30/2015	15507	01/21/2015
CMS RO				

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/4/2014			

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Facility ID: 00568

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(L3) **PLEASANT MANOR INC**
(L4) **27 BRAND AVENUE**
(L5) **FARIBAULT, MN** (L6) **55021**

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 **12/04/2014** (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**
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03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **65** (L18)

13.Total Certified Beds **65** (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
	65			
(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 :
Mary Bruess, HFE NE II 12/29/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 01/12/2015 (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
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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
01/21/1967
(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 4554

December 17, 2014

Mr. Chris Krebsbach, Administrator
Pleasant Manor Inc
27 Brand Avenue
Faribault, Minnesota 55021

RE: Project Number S5090024

Dear Mr. Krebsbach:

On December 4, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

Email: gayle.lantto@state.mn.us
Telephone: (651) 201-3794
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 January 13, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 March 4, 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 June 4, 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
Health Regulations Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124   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
	245090	A. BUILDING ______ B. WING ______	**12/04/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR INC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(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 will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to consider the use of a device as potentially restraining for 1 of 1 resident (R63) who utilized a body pillow. Findings include: R63 was observed on 12/2/14, at 1:53 p.m. while in bed. A perimeter defining mattress was on the bed, and the bed was up against the wall. On the opposite side of the bed, a body pillow was tucked underneath the fitted sheet. The following day, at 8:07 a.m. the resident was not in the room. Two signs were posted on the	F 221	F 221 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: a. With respect to R63 a physical device	12/29/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 12/29/2014

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING ______ B. WING ______	12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR INC	27 BRAND AVENUE FARIBAULT, MN 55021

(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 221	Continued From page 1 walls in the room, both dated 8/14/14. The signs directed staff to place body pillow to outer edge of bed, underneath the fitted sheet at all times when the resident was in bed. The signs were initialed with a registered nurse's initials. Later that day at 1:57 p.m. R63 was again observed in bed with the body pillow placed underneath the fitted sheet on the exit side of the bed. Fall log reports were reviewed for R63. On 8/4/14, the resident was found on her hands and knees stating she was trying to get up. Intervention changes were to tuck the body pillow underneath the fitted sheet. On 8/14/14, at 3:42 p.m. the resident was found on the floor, having attempted to get out of bed on her own. No further falls were noted in the log. R63's care plan dated 8/26/14 indicated a risk for falls related to swinging her legs out of bed at night, knees tended to buckle, weakness, and dementia. Falls were noted on 6/2/14, 6/3/14, 8/11/14, and 8/4/14. Interventions included "body pillows to outside of bed under fitted sheet at all times while in bed," and the use of a perimeter defining mattress. R63's fall assessment dated 11/16/14, noted R63 was at high risk for falls. A physical device evaluation dated 11/19/14 indicated "Other: body pillow." The Minimum Data Set (MDS) dated 11/25/14, indicated the resident was cognitively impaired, was not restrained in bed (not noted on any MDS since the resident's admission, nor after the body pillow was tucked into the fitted sheet), required extensive assistance with bed mobility, and was unsteady without assistance when transferring.	F 221	assessment was completed on 12-23-2014.Care plan and Nursing Assistant assignment sheet updated to reflect current needs b. All residents requiring the use of a device for safety and / or positioning will be assessed for their individual needs upon admission, quarterly, with a significant change and with the initiation of a new device. Care plans and NAR sheets will be revised for individualized needs. c. All licensed staff have been re-educated on appropriate procedure of completion of the Physical Device assessment on 12-10-2014. d. DNS/Designee will audit 2 resident s record per week for 4 weeks and then 1 resident s record for 8 weeks. This data will be shared at the next quality assurance meeting by the DNS/designee for input and further direction. e. DNS responsible for completion	

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	245090	A. BUILDING ______ B. WING ______	12/04/2014

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F 221	Continued From page 2	F 221		

RN-A was interviewed on 12/3/14, at 1:34 p.m. She explained R63 had experienced two falls related to self-transfers. R63 fell on 8/4/14, after self-transferring and sustained an abrasion/bruise to her knee. At that time the staff was "educated" regarding the use of the body pillow. On 8/11/14, she again attempted to self-transfer out of bed, and fell, sustaining a skin tear on her arm and a bump to her forehead. RN-A explained that the body pillow had been utilized since the resident's admission two years prior.

On 12/3/14, at 2:20 p.m. a nursing assistant (NA)-A was interviewed. She said R63 could not roll over the body pillow when in bed. She thought perhaps the resident could have pulled the pillow out from under the sheet, but had never seen the resident attempt to do so.

A registered physical therapist (RPT)-A stated on 12/3/14, at 3:15 p.m. that she thought R63 would not have had the ability to get up to a sitting position to get out of bed, however, "could possibly roll out of bed." RPT-A said R63 had cognitive impairment that would have prevented her from systematically move from a lying to standing position.

RN-A was interviewed on 12/3/14, at 3:29 p.m. and verified a restraint assessment had not been completed related to the use of the body pillow. She explained the pillow was being used to "keep from rolling out of bed," but "unfortunately" there were no assessments related to the use of the device for R63.

The director of nursing (DON) was interviewed on 12/4/14, at 7:44 a.m. She said the body pillow had been utilized for R63 since her admission

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F 221	Continued From page 3 more than two years prior, and she had used it at her previous residence. After the second fall it was determined the body pillow would be tucked under the fitted sheet. The DON reported the facility had not conducted an assessment to determine if the device was a restraint for R63. The staff had not determined whether the resident could have independently removed the device. The DON confirmed a Physical Device Assessment dated 8/25/14, did not include information as to whether the resident could independently remove the device either. "There should have been an explanation as to whether the device was being appropriately used on the assessment. According to the DON, this was the nurse manager's responsibility. The DON said the facility did not have a policy related to the use of body pillows.	F 221		
F 257 SS=E	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain comfortable room temperatures for 5 of 20 residents (R67, R17, R21, R33, R76) who complained of cold temperatures, and to maintain appropriate temperatures in bathrooms for 3 of 35 residents (R76, R54, R7) whose bathrooms were observed. Findings include:	F 257	F 257 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed	12/29/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 257	Continued From page 4 On 12/1/14, at 12:00 p.m. during the initial facility tour, the air temperature in resident rooms and common areas was notably cool. R67 stated regarding the building on 12/1/14, at 4:14 p.m. during an interview, "It's too cold." At 4:30 p.m. R17, R21, and R33 also complained the common area of the west wing was "cold." R76 reported he was cold at the time of an interview on 12/2/14, at 11:01 a.m. and added, "The bathroom is cold and I have to wear a sweatshirt to bed because it's so cold." R76 said he liked his room at cooler at 65 degrees Fahrenheit (F) and could handle that temperature. When resident bathrooms were observed on 12/2/14, at 11:52 a.m. air temperatures in R76, R54 and R7's bathrooms felt cold. During the environmental tour on 12/4/14, at 8:30 a.m. the maintenance manager (MM) verified he had received several ongoing grievances regarding cold temperatures throughout the building. The MM explained they had replaced the windows in the west common area and were also looking to replace the other windows throughout the building. He stated staff were to inform maintenance staff when residents complained of cold temperatures. However, he did not maintain a log of those complaints, nor maintain a temperature log of resident rooms or common areas. He said room temperatures were usually set "in the 70's" but did not provide documentation of the actual temperatures, and had no way of checking air temperatures. The MM said only some of the rooms had individual thermostats and could be adjusted. On 12/4/14, at 8:00 a.m. the maintenance	F 257	solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: a. With respect to R67, R17, R21, R33, R76, R54, and R7, facility installed new weather-stripping on the North Fire Door and window sealers were added to the resident rooms. Monitoring of room temperatures have revealed a maintained temperature between 71 and 75 degrees. b. All residents have the potential to be affected by cold rooms. Maintenance staff perform daily review or room temperatures throughout the facility. c. Maintenance staff have been re-educated on proper room temperature and have created a temperature log they will track each week. d.All staff have been re-educated on 12-10-2014 regarding appropriate procedure of reporting a room temperature grievance or complaint. e. Temperature Audits will be done on 3 resident s rooms/ bathrooms per week for 4 weeks and the 2 resident rooms / bathroom for 8 weeks. This data will be shared at the next quality assurance meeting by the ED/designee for input and further direction. f. ED/designee is responsible for completion	

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F 257	Continued From page 5 assistant (MA) verified the building was cold and said they had placed plastic on the windows to reduce the cold in the prior years. He stated daily temperatures were taken in the building and they tried to adjust the temperatures to temperatures that were comfortable for the residents. The MA verified some of the resident bathrooms feel "ice cold" and two resident rooms on the 100 wing were cold because of their location at the end of the hallway by the door. On 12/4/14, at 10:30 a.m. a registered nurse (RN)-A verified she had received grievances from residents who had complained of cold temperatures, however, she had not kept a log of their concerns. She explained she offered residents additional clothing and/or blankets, and reported the problem to the maintenance staff so the temperatures could be adjusted. Although a bid dated 12/4/14 was provided for the installation of cove heaters for two resident rooms was provided, no purchase agreement had been signed or other confirmation verifying if and when the heaters would be installed. A request was made for evidence of the facility's system and related policies for measuring and maintaining comfortable room temperatures, was but was not provided.	F 257		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive	F 272		12/29/14

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F 272	Continued From page 6 assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to adequately assess whether a device was potentially restraining for 1 of 1 resident (R63) who was potentially restrained.	F 272	F 272 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the	

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F 272

Continued From page 7

Findings include:

R63 was observed on 12/2/14, at 1:53 p.m. while in bed. A perimeter defining mattress was on the bed, and the bed was up against the wall. On the opposite side of the bed, a body pillow was tucked underneath the fitted sheet.

The following day, at 8:07 a.m. the resident was not in the room. Two signs were posted on the walls in the room, both dated 8/14/14. The signs directed staff to place body pillow to outer edge of bed, underneath the fitted sheet at all times when the resident was in bed. The signs were initialed with a registered nurse's initials. Later that day at 1:57 p.m. R63 was again observed in bed with the body pillow placed underneath the fitted sheet on the exit side of the bed.

R63's fall assessment dated 11/16/14, noted R63 was at high risk for falls. A physical device evaluation dated 11/19/14 indicated "Other: body pillow." The Minimum Data Set (MDS) dated 11/25/14, indicated the resident was cognitively impaired, was not restrained in bed (not noted on any MDS since the resident's admission, nor after the body pillow was tucked into the fitted sheet), required extensive assistance with bed mobility, and was unsteady without assistance when transferring.

RN-A was interviewed on 12/3/14, at 1:34 p.m. She explained R63 had experienced two falls related to self-transfers. R63 fell on 8/4/14, after self-transferring and sustained an abrasion/bruise to her knee. At that time the staff was "educated" regarding the use of the body pillow. On 8/11/14, she again attempted to self-transfer out of bed,

F 272

facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to:
a. With respect to R63 a physical device assessment was completed on 12-23-2014.Care plan and Nursing Assistant assignment sheet updated to reflect current needs
b. All licensed staff have been re-educated on appropriate procedure of completion of the Physical Device assessment on 12-10-2014.updated to reflect current needs
c. Residents will continue to be assessed for their individual physical device use needs upon admission, quarterly, with a significant change and with the initiation of a new device. Care plans will be reviewed for individualized positioning needs.
d. All licensed staff have been re-educated on appropriate procedure of completion of the Physical Device assessment on 12-10-2014.
e. DNS/Designee will audit 2 medical records for positioning assessment and individualized care plans for 4 weeks and then 1 medical records for 8 weeks. The data will be shared at the next quality assurance meeting by the DNS/designee for input and further direction.
f. DNS responsible

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 272	Continued From page 8 and fell, sustaining a skin tear on her arm and a bump to her forehead. RN-A explained that the body pillow had been utilized since the resident's admission two years prior. On 12/3/14, at 2:20 p.m. a nursing assistant (NA)-A was interviewed. She said R63 could not roll over the body pillow when in bed. She thought perhaps the resident could have pulled the pillow out from under the sheet, but had never seen the resident attempt to do so. A registered physical therapist (RPT)-A stated on 12/3/14, at 3:15 p.m. that she thought R63 would not have had the ability to get up to a sitting position to get out of bed, however, "could possibly roll out of bed." RPT-A said R63 had cognitive impairment that would have prevented her from systematically move from a lying to standing position. RN-A was interviewed on 12/3/14, at 3:29 p.m. and verified a restraint assessment had not been completed related to the use of the body pillow. She explained the pillow was being used to "keep from rolling out of bed," but "unfortunately" there were no assessments related to the use of the device for R63. The director of nursing (DON) was interviewed on 12/4/14, at 7:44 a.m. She said the body pillow had been utilized for R63 since her admission more than two years prior, and she had used it at her previous residence. After the second fall it was determined the body pillow would be tucked under the fitted sheet. The DON reported the facility had not conducted an assessment to determine if the device was a restraint for R63. The staff had not determined whether the	F 272		

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F 272	Continued From page 9 resident could have independently removed the device. The DON confirmed a Physical Device Assessment dated 8/25/14, did not include information as to whether the resident could independently remove the device either. "There should have been an explanation as to whether the device was being appropriately used on the assessment. According to the DON, this was the nurse manager's responsibility. The DON said the facility did not have a policy related to the use of body pillows.	F 272		
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 accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to provide services in accordance with the residents' care plan for 1 of 3 residents (R7) identified at risk for developing pressure ulcers and who was dependent on staff for repositioning and incontinence care. Findings include: R7's care plan dated 5/19/14, indicated the resident "Requires 2 staff to reposition and check for incontinence care every 2-3 hours." R7's Minimum Data Set assessment dated 9/17/14, noted the resident was cognitively intact. During observations on 12/2/14, from 8:00 a.m.	F 282	F 282 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: a. With respect to R7 the nursing assistant providing cares to R7 received immediate coaching/ re-education on	12/29/14

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F 282	Continued From page 10 until 11:30 a.m. R7 remained seated in his wheel chair for three hours without a position change. When interviewed on 12/2/14, at 10:23 a.m. R7 expressed he sometimes he sat "too long," and was feeling some discomfort in his legs and buttocks. R7 was unable to lift his buttocks or change position while sitting in the wheel chair. R7 reported he was up before 6:00 a.m. that day, and had not changed positions since that time. Four nursing assistants (NAs) were interviewed on 12/2/14, at 11:33 a.m. NA-A explained she had planned on assisting R7 back to bed after breakfast, but was unable to leave the dining room. Instead, she assisted the resident to the day room, and then got busy assisting other residents. She verified she had assisted R7 out of bed before 6:00 a.m. NA-B, NA-C and NA-D all then verified they had not assisted with any cares for R7 since before 6:00 a.m. which was approximately five and one half hours earlier. NA-A, NA-B, NA-C, and NA-D validated R7 should have been assisted with repositioning and checked and changed for incontinence every 2-3 hours, but had been sitting in his wheelchair for approximately five and a half hours without repositioning or an incontinence check.	F 282	toileting, repositioning and following the plan of care. b. All residents requiring assistance with toileting and repositioning needs have had the care plan and NAR sheet reviewed to assure to meet individual needs. c. All staff were re-educated on following the plan of care related to toileting and repositioning on 12-10-2014. d .DNS/Designee will audit for repositioning and toileting needs of 3 residents per week for 4 weeks then 2 per week for 8 weeks. The data will be shared at the next quality assurance meeting by the DNS/designee for input and further direction	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and	F 314		12/29/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 314	Continued From page 11 services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure timely repositioning to minimize the risk for pressure ulcer development for 1 of 3 residents (R7) identified at risk for pressure ulcer development. Findings include: During observations on 12/2/14, from 8:00 a.m. until 11:30 a.m. R7 remained seated in his wheel chair for three hours without a position change. When interviewed on 12/2/14, at 10:23 a.m. R7 expressed he sometimes he sat "too long," and was feeling some discomfort in his legs and buttocks. R7 was unable to lift his buttocks or change position while sitting in the wheel chair. R7 reported he was up before 6:00 a.m. that day, and had not changed positions since that time. Four nursing assistants (NAs) were interviewed on 12/2/14, at 11:33 a.m. NA-A explained she had planned on assisting R7 back to bed after breakfast, but was unable to leave the dining room. Instead, she assisted the resident to the day room, and then got busy assisting other residents. She verified she had assisted R7 out of bed before 6:00 a.m. NA-B, NA-C and NA-D all then verified they had not assisted with any cares for R7 since before 6:00 a.m. which was approximately five and one half hours earlier. NA-A, NA-B, NA-C, and NA-D validated R7 should have been assisted with repositioning	F 314	F314 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: a.With respect to R7 a comprehensive review of toileting and positrioning needs, care plan and NAR sheet was performed. b .All residents requiring assistance with toileting and repositioning needs have had the care plan and NAR sheet reviewed to assure to meet individual needs. c.All staff were re-educated on following the plan of care related to toileting and repositioning on 12-10-2014. d.DNS/Designee will audit for repositioning and toileting needs of 3 residents per week for 4 weeks then 2 per week for 8 weeks. The data will be shared at the next quality assurance meeting by the DNS/designee for input and further direction. e. DNS is responsible.	

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F 314	Continued From page 12 every 2-3 hours, but had been sitting in his wheelchair for approximately five and a half hours without repositioning. R7 was assisted to bed by NA-A and NA-B and the use of a mechanical lift on 12/2/14, at 11:40 a.m. R7's skin was bright red with crevices and craters on the buttocks and posterior thighs where there had been wrinkling of the incontinence brief and clothing. NA-A and NA-B verified the condition of the resident's skin at the time of the observation. The care plan dated 5/19/14, for R7 directed staff to assist the resident with repositioning every two-three hours. The Braden Scale for Predicting Pressure Sore Risk and dated 9/15/14, indicated the resident was at moderate risk for pressure ulcer development.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure incontinence	F 315	F 315 The preparation of the following plan of	12/29/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING ______ B. WING ______	12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR INC	**27 BRAND AVENUE FARIBAULT, MN 55021**

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F 315	Continued From page 13 care was provided for 1 of 3 residents (R7) who were incontinent and dependent on staff for toileting needs. Findings include: R7 remained seated in his wheel chair for three hours without being checked and changed for incontinence, during observations on 12/2/14, from 8:00 a.m. until 11:30 a.m. When interviewed on 12/2/14, at 10:23 a.m. R7 reported he was up before 6:00 a.m. that day and had not had his incontinence brief checked since he got up. Four nursing assistants (NAs) were interviewed on 12/2/14, at 11:33 a.m. NA-A explained she had planned on assisting R7 back to bed after breakfast, but was unable to leave the dining room. Instead, she assisted the resident to the day room, and then got busy assisting other residents. She verified she had assisted R7 out of bed before 6:00 a.m. NA-B, NA-C and NA-D all then verified they had not assisted with any cares for R7 since before 6:00 a.m. which was approximately five and one half hours earlier. NA-A, NA-B, NA-C, and NA-D validated R7 should have been checked and changed for incontinence every 2-3 hours, but had been sitting in his wheelchair for approximately five and a half hours without an incontinence check. R7 was assisted to bed by NA-A and NA-B and the use of a mechanical lift on 12/2/14, at 11:40 a.m. NA-A and NA-B the nursing assistants confirmed R7 had been incontinent of a large amount of strong smelling urine in the incontinence brief.	F 315	correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: a.With respect to R7 a comprehensive reivew of toileting and positioning needs, care plan and NAR sheet was performed. b.All residents requiring assistance with toileting and repositioning needs have had the care plan and NAR sheet reviewed to assure to meet individual needs. c.All staff were re-educated on following the plan of cae related to toileting and repositioning on 12-10-2014. d.DNS/Designee will audit for repositioning and toileting needs of 3 residents per week for 4 weeks then 2 per week for 8 weeks. The data will be shared at the next quality assurance meeting by the DNS/designee for input and further direction. e. DNS is responsible.	

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PLEASANT MANOR INC	**27 BRAND AVENUE** **FARIBAULT, MN 55021**

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F 315	Continued From page 14 Document review of the plan of care dated 5/19/14, directed staff to "Check every 2-3 hours for incontinence. Provide incontinence care." The Minimum Data Set dated 9/15/14, indicated R7 was always incontinent of urine.	F 315		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 329	F 329	12/29/14

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F 329	Continued From page 15 review, the facility failed to ensure target behaviors were monitored to determine efficacy of psychotropic medication for 1 of 5 residents (R67) reviewed for unnecessary medications. Findings include: R67 was observed on 12/3/14, at 7:52 a.m. to be in bed, sound asleep. At 9:18 a.m. the resident was awake, but remained in bed. R67 remained in bed on 12/3/14, from 7:52 a.m. until 3:00 p.m. R67's current physician orders, signed on 11/24/14, indicated: "Risperdal (risperidone) 0.5 mg [milligram] by mouth two times a day related to agitation/paranoia. May use tab [tablet form] or liquid." R67's record revealed Risperdal was initiated at the facility on 3/7/14, following admission to a geriatric psychiatric unit from 2/27/14 to 3/7/14. The quarterly Minimum Data Set (MDS) dated 7/9/14, and annual MDS dated 10/7/14, identified R67 as having diagnoses of depression and dementia. The MDS did not identify any delirium or behavioral symptoms (physical or verbal) or psychosis (hallucination or delusions). The MDS did identify mood symptoms such as little interest or pleasure in doing things, feeling down, depressed or hopeless and feeling tired and having little energy. The MDS also indicated resident received antipsychotic, antidepressant and hypnotic medication for seven days during the assessment period. The annual Care Area Assessment (CAA) for psychotropic drug use dated 10/7/14, indicated, "Has a diagnosis of neurodegenerative dementia with depression and behavioral complications,	F 329	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: a. In respect to R67 a comprehensive medication assessment was performed, care plan has been revised to include appropriate monitoring related to medications. b. All residents' medication records are reviewed upon admission, quarterly, with a significant change in condition and upon initiation of a new medication. c. All residents medication regime was reviewed by consultant Pharmacist on 12-19-2014 d. All licensed staff were re-educated regarding medication monitoring on 12-10-2014. e. DNS or designee will audit 3 medical records a week X 4 weeks then 2 medical records a week X 8 weeks for target behavior monitoring. The data will be shared at the next quality assurance meeting by the DNS/designee for input and further direction. f. DNS responsible.	

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F 329	Continued From page 16 including paranoid psychosis, insomnia, hx [history] of aggressive behaviors towards staff, hx of suicidal ideation, short term stay at [name of geriatric psychiatric unit] to work with and establish an effective med [medication] regime. Will continue to monitor [R67] for potential side effects of medication as well as effectiveness of them." The areas of delirium, mood state or behavioral symptoms did not trigger for review. R67's care plan dated 2/25/14, identified behavior problem as episodes of being physically and verbally abusive towards staff. "Resident has demonstrated this inappropriate behavior by throwing things and has been physically aggressive towards staff by hitting them during cares." The approaches directed staff to administer medication as ordered, assist resident to develop more appropriate methods of coping and interacting, encourage to express feelings appropriately, let staff know when getting upset, if reasonable, discuss behavior with resident, explain/reinforce why behavior was inappropriate and/or unacceptable, observe behavior episodes and attempt to determine underlying cause, consider location, time of day, persons involved, and situations and document behavior and potential causes. Review of the interdisciplinary progress notes, revealed a note dated 10/7/14, Behavior/Mood Evaluation, "Has no ability to cope, becomes agitated, strikes out verbally and/or physically...Behaviors is not new or worsening in the past 7 days, Target behaviors noted: yelling/screaming at staff, throwing objects, hitting staff. Target behaviors and interventions are care planned.	F 329		

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F 329	Continued From page 17	F 329		

Review of the Medication Administration Record from 3/14 to 11/14 revealed no identification or monitoring of target behaviors.

Review of the nursing assistant point of care documentation revealed the following behaviors was identified from 3/7/14 to 8/12/14; yelling and screaming (9 times), abusive language (4 times), frequent crying (1 time), threatening behavior (5 times), sexually inappropriate behavior (5 times), rejection of cares (1 time), repeats movement(2 times). No behaviors was documented from 8/12/14 to 12/4/14 and no interventions was documented when behavior did occur.

In an interview with a nursing assistant (NA)-G on 12/4/14, at 8:15 a.m. the NA reported R67 refused to get out of bed, only getting up weekly to go to the beauty shop. Sometimes the resident also refused to accept staffs' assistance to sit up in bed, and resisted by pushing back on staff, causing her to fall to the side. NA-G reported the resident was generally "pretty cooperative." NA-G showed surveyor the facility's documentation system, Point of Care. Each resident was in the system and a place to document behaviors including frequent crying, repetitive movement, yelling/screaming, kicking/hitting, pushing, grabbing, pinching/scratching/spitting, biting, wandering, abusive language, threatening behavior, sexually inappropriateness, rejection of cares or none of the above were observed.

Interview with a registered nurse (RN)-A on 12/3/14, at 10:13 a.m. indicated R67 was currently prescribed antipsychotic medication and target behaviors and relevant interventions were to be identified and monitored on all shifts on the resident's Treatment Administration Record

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F 329	Continued From page 18 (TAR). RN-A proceeded to show an example of another resident's record which identified target behaviors and interventions. RN-A further explained NAs were were to alert the nurse to all resident behaviors. In an interview with director of nursing (DON) on 12/4/14, at 11:23 a.m. the DON explained the electronic point of care was utilized by the NAs for documentation of resident cares, was the same for all residents in the facility. The DON further stated R67's target behaviors and relevant interventions should have been identified on the TAR for monitoring on all shifts. The DON acknowledged this was not completed from 3/14 through 11/14. The facility's undated Behavior Monitoring Guideline policy directed staff as follows: "Daily behavior monitoring is required for those residents on anti-psychotic and antianxiety medications. This monitoring is completed on the MED PASS form. Behavior monitoring allows you to evaluate the interventions and effectiveness of medications being used. Residents receiving psychoactive medications must have appropriate diagnosis and target behavior monitored."	F 329		

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

F5090024

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
	245090	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	12/04/2014

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Pleasant Manor Nursing Home was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Pleasant Manor Nursing Home is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1963 and was determined to be of Type II(111) construction. In 1978, addition was constructed to the Northwest Wing that was determined to be of Type II(111) construction. In 1996, another addition was added to the Southeast Wing and was determined to be Type II (111). Because the original building and the 2 additions are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 65 beds and had a census of 63 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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

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

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

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	245090	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	12/04/2014

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K 000	Continued From page 1 MET. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 000		

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 4554

December 17, 2014

Mr. Chris Krebsbach, Administrator
Pleasant Manor Inc
27 Brand Avenue
Faribault, Minnesota 55021

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5090024

Dear Mr. Krebsbach:

The above facility was surveyed on December 1, 2014 through December 4, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to:

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

Email: gayle.lantto@state.mn.us
Telephone: (651) 201-3794
Fax: (651) 201-3790

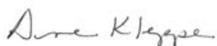
We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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,



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

Enclosure(s)
cc: Original - Facility
Licensing and Certification File