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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: K6L0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00477

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245537**

2.STATE VENDOR OR MEDICAID NO.
(L2) **328542100**

3. NAME AND ADDRESS OF FACILITY
(L3) **MINNEWASKA COMMUNITY HEALTH SERVICES**
(L4) **605 MAIN STREET, PO BOX 40**
(L5) **STARBUCK, MN** (L6) **56381**

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 **03/19/2015** (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)
12/31

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
X 8. Patient Room Size
__ 9. Beds/Room

* Code: **A, 8** (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):

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Tammy Williams, HFE NEII — 03/26/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 03/26/2015 (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
07/27/1989
(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
03/23/2015
(L33)

DETERMINATION APPROVAL

CCN: 24-5537

On March 19, 2015 a Post Certification Revisit (PCR) was completed at this facility an verified correction of deficiencies issued pursuant to the standard survey had been corrected. Refer to the CMS 2567b for the results of this visit.

In addition, we have recommended CMS approve the waiver the facility requested involving the health deficiency cited at F458.

Effective February 27, 2015 the facility is certified for 65 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245537

March 26, 2015

Mr. Christopher Knoll, Administrator
Minnewaska Community Health Services
605 Main Street, PO Box 40
Starbuck, Minnesota 56381

Dear Mr. Knoll:

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 February 27, 2015 the above facility is certified for:

65 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 65 skilled nursing facility beds.

Your request for waiver of F458 has forwarded to CMS and recommended for approval based on the submitted documentation.

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 eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
March 25, 2015

Mr. Christopher Knoll, Administrator
Minnewaska Community Health Services
605 Main Street, PO Box 40
Starbuck, Minnesota 56381

RE: Project Number S5537026

Dear Mr.. Knoll:

On February 13, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 29, 2015. 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 March 19, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 29, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 27, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 29, 2015, effective February 27, 2015 and therefore remedies outlined in our letter to you dated February 13, 2015, will not be imposed.

Submitted documentation supporting the facility's request for a waiver involving deficiency cited at F458 was previously forwarded to CMS. Approval of the waiver request was recommended

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 related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

5537r15

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245537	A. Building B. Wing	3/19/2015

Name of Facility	Street Address, City, State, Zip Code
MINNEWASKA COMMUNITY HEALTH SERVICES	605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **02/27/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **02/27/2015**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **02/27/2015**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **02/27/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **02/27/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **02/27/2015**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **02/27/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **02/27/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	JS/mm	03/26/2015	32603	03/26/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/29/2015			

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

April 8, 2015

Mr. Christopher Knoll, Administrator
Minnewaska Community Health Services
605 Main Street, PO Box 40
Starbuck, Minnesota 56381

Re: Reinspection Results - Project Number S5537026

Dear Mr. Knoll:

On March 19, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 29, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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 related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

5537r15

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00477	A. Building B. Wing	3/19/2015

Name of Facility	Street Address, City, State, Zip Code
MINNEWASKA COMMUNITY HEALTH SERVICES	605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20302** Reg. # **MN State Statute 144.6503** LSC	Correction Completed **02/27/2015**	ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp. 3** LSC	Correction Completed **02/27/2015**	ID Prefix **21426** Reg. # **MN St. Statute 144A.04 Sul** LSC	Correction Completed **02/27/2015**
ID Prefix **21530** Reg. # **MN Rule 4658.1310 A.B.C** LSC	Correction Completed **02/27/2015**	ID Prefix **21535** Reg. # **MN Rule4658.1315 Subp.1** LSC	Correction Completed **02/27/2015**	ID Prefix **21620** Reg. # **MN Rule 4658.1345** LSC	Correction Completed **02/27/2015**
ID Prefix **21805** Reg. # **MN St. Statute 144.651 Sul** LSC	Correction Completed **02/27/2015**	ID Prefix **21990** Reg. # **MN St. Statute 626.557 Sul** LSC	Correction Completed **02/27/2015**	ID Prefix **21995** Reg. # **MN St. Statute 626.557 Sul** LSC	Correction Completed **02/27/2015**
ID Prefix **22155** Reg. # **MN Rule 4658.4105 Subp. 1** LSC	Correction Completed **02/27/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	JS/mm	03/26/2015	32603	03/26/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/29/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: K6L0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00477

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245537**

2.STATE VENDOR OR MEDICAID NO.
(L2) **328542100**

3. NAME AND ADDRESS OF FACILITY
(L3) **MINNEWASKA COMMUNITY HEALTH SERVICES**
(L4) **605 MAIN STREET, PO BOX 40**
(L5) **STARBUCK, MN** (L6) **56381**

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 **01/29/2015** (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)
12/31

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B, 8** (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 :
Christina Martinson HFE NEII 02/21/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 03/09/2015 (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
(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
07/27/1989
(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

CCN: 24-5537

On January 29, 2015 a standard survey was completed at this facility. Deficiencies were found. The facility has been given an opportunity to correct before remedies would be imposed. Post Certification Revisit (PCR) to follow.

In addition, the facility has been approved for waiver involving defciency cited at F0458, Bedrooms Measure At Least 80 SQ FT/resident. Refer to the CMS 2567 for both health and life safety code, along with the facility's plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
February 13, 2015

Mr. Christopher Knoll, Administrator
Minnewaska Community Health Services
605 Main Street, PO Box 40
Starbuck, Minnesota 56381

RE: Project Number S5537026

Dear Mr. Knoll:

On January 29, 2015, 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;

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

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

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

<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:

Jessica Sellner, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: Jessica.sellner@state.mn.us

Phone: (320) 223-7345
Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 10, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 29, 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 July 29, 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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
mark.meath@state.mn.us

Telephone: (651) 201-4118
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s553715

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245537	A. BUILDING _____ B. WING _____	01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEWASKA COMMUNITY HEALTH SERVICES	605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381

(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 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated	F 225		2/27/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/19/2015

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

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F 225	Continued From page 1 representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to immediately report to the administrator and state agency (SA), and complete a thorough investigation, for 1 of 1 resident (R37) with a bruise of unknown origin. Findings include: R37's annual Minimum Data Set (MDS) dated 11/6/14, identified R37 had severely cognitive impairment, required extensive staff assistance for all areas of daily living (ADL), and required a mechanical standing lift and assistance of two staff for all transfers R37's care area assessment (CAA) dated 11/12/14, identified R37 had diagnoses including dementia with Lewy bodies and progressing Parkinson's Disease, and R37 was dependent on staff to anticipate needs and rarely/never made decisions regarding daily tasks of life. Review of R37 Progress Notes dated 1/27/15, indicated R37 had large bruises under left breast, left shoulder, and hand. During interview on 1/29/15, at 9:48 a.m. nursing assistant (NA)-B stated the only bruise she was aware that R37 had was a bruise on her left hand	F 225	It is the policy of Minnewaska Lutheran Home to complete background screening checks and criminal conviction investigation checks on all individuals making application for employment with this facility. It is also the policy of the facility to investigate all unexplained injuries, including bruises, abrasions, and injuries of unknown source. The policy states that "the administrator or his designee shall be notified immediately of any resident sustaining an injury, unexplained injury or harm." The Director of Nursing Services or her designee will conduct an investigation and record this information into the resident's clinical record. Per facility policy, immediate reporting to the OHFC must be done when an allegation of mistreatment or abuse is alleged. The facility policy was reviewed and stands as written. In the instance of resident R37, a report was filed with OHFC on 1/30/2015 and received notice on 2/03/2015 that there will be no further investigation. Per facility investigation, it was determined that the belt from the PAL lift was either fastened or slipped up on top of her breasts during a transfer causing bruising to her (Lt.)	

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F 225	Continued From page 2 which was not new, and NA-B thought it came from the resident bumping the table. NA-B not aware of any other bruising R37 had, however, if she noted bruising she would report it to the nurse immediately. During interview on 1/29/15, at 9:53 a.m. licensed practical nurse (LPN)-A was not aware of any bruising R37 had, but stated she would look at the Progress Notes. After consulting R37's medical record, LPN-A stated it appeared there was a bruise under R37's breast. LPN-A was not aware of the cause, and although she had not seen the bruise, she stated it could possibly have come from the mechanical lift sling. LPN-A confirmed R37's bruise was discovered on 1/27/15, according to the Progress Notes. During interview on 1/29/15, at 9:56 a.m. registered nurse (RN)-A stated on 1/27/15, staff had reported R 37 had a large bruise under her left breast. RN-A stated no one was aware of how the bruise happened, there was no physical assessment including measuring of the bruise, no report of the bruise of unknown origin had been made to the state agency and/or administrator, and no investigation had been started. RN-A stated when a resident had a bruise/ injury of unknown origin, staff is instructed to ask the resident how it happened, assess the injury, and if the cause of the bruise or injury was unknown, a report would be filed with the state agency. RN-A stated she had talked to aides regarding R37's bruising and she felt it was due to the mechanical lift sling, however, RN-A stated she did not observe the bruising, nor did she document any investigation or interviews. During interview on 1/29/15, at 10:07 a.m. NA-C	F 225	breast. The belt needs to be fastened under her breasts to be used appropriately. Staff were educated immediately and education provided about proper transfer technique at an All Staff In-service on 2/17/15. Staff involved in not reporting the bruises were educated on the facility policy and the need to report immediately to the Administrator, the DON, and OHFC when the origin is unknown. Education regarding immediate reporting was also presented at the All Staff In-service on 2/17/15. The DON or her designee will evaluate all residents utilizing the PAL lift for transfers and will be determined if staff are using it appropriately. The DON will monitor daily any incident reports with the interdisciplinary team and audit reports for one quarter and submit these findings for review and recommendations to the Quality Assurance Committee at the June, 2015 meeting, to ensure that all reports are being filed immediately and timely. Staff education will be presented on 02/17/15 and F/U with those who did not attend by 2/27/15. Date corrected: February 27, 2015	

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F 225	Continued From page 3	F 225		

stated she gave R37 a bath on 1/27/15, and noticed the large bruise under the residents left breast and reported it to the nurse.

During observation on 1/29/15, at 10:08 a.m. NA-C and LPN-A transferred R37 from the recliner to the wheelchair with the mechanical standing lift. RN-A was in the room to assess R37's bruising. RN-A used a paper measuring device to measure a dark, purple bruise on R37's lateral left breast, which measured 6 cm (centimeters) x 7 cm. RN-A stated the smaller bruising on R37's hand and lower arms were older bruises and she believed they came from R37 bumping the table. RN-A stated R37 was not cognitive enough to recall how the bruise happened. RN-A stated she believed the bruise was possibly caused from the mechanical lift sling, but could not be sure, and she was going to report the bruise of unknown origin to the director of nursing (DON) so a report can be made to the state agency and an investigation could begin.

During interview on 01/29/15, at 10:19 a.m. the DON stated she was not made aware of the bruising of unknown origin for R37. The DON stated staff are expected to complete incident reports on all bruises of unknown origin, and if the cause is not known staff are expected to immediately contact the administrator, DON, and make the initial report to the state agency, and then begin the investigation.

During interview on 01/29/15, at 10:34 a.m. the administrator confirmed he was not aware of R37's bruise of unknown origin which was discovered on 1/27/15. The administrator stated all staff are expected to immediately report all bruising of unknown origin immediately to the

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F 225	Continued From page 4 administrator and state agency, and then investigate. The facility undated Reporting/Investigating Resident Accidents/Incidents policy, directed staff to report all injuries of unknown source to appropriate state agencies promptly, report to the facility administrator, and conduct a thorough investigation.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement their abuse prohibition policies and procedures for immediate reporting to the facility administrator and state agency (SA) and thorough investigations for 1 of 1 resident (R37) with a bruise of unknown origin. Findings include: The facility undated Reporting/Investigating Resident Accidents/Incidents policy, directed staff to report all injuries of unknown source to appropriate state agencies promptly, report to the facility administrator, and conduct a thorough investigation. R37's annual Minimum Data Set (MDS) dated	F 226	It is the policy of Minnewaska Lutheran Home to follow the policy and procedure for immediately reporting issues of Vulnerable Adult. The policy states that immediate reporting shall take place when an allegation of mistreatment or abuse is alleged. Injuries of unknown origin include bruises, abrasions, and any other injury. Education was provided to staff on 02/17/2015, to immediately notify the administrator and DON if an alleged violation have occurred to ensure reporting is done according to the MDH requirements. In the instance of resident R37, a report has been filed with OHFC on 1/30/15 with results of the investigation submitted on	2/27/15

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F 226	Continued From page 5 11/6/14, identified R37 had severely cognitive impairment, required extensive staff assistance for all areas of daily living (ADL), and required a mechanical standing lift and assistance of two staff for all transfers R37's care area assessment (CAA) dated 11/12/14, identified R37 had diagnoses including dementia with Lewy bodies and progressing Parkinson's Disease, and R37 was dependent on staff to anticipate needs and rarely/never made decisions regarding daily tasks of life. Review of R37 Progress Notes dated 1/27/15, indicated R37 had large bruises under left breast, left shoulder, and hand. During interview on 1/29/15, at 9:48 a.m. nursing assistant (NA)-B stated the only bruise she was aware that R37 had was a bruise on her left hand which was not new, and NA-B thought it came from the resident bumping the table. NA-B not aware of any other bruising R37 had, however, if she noted bruising she would report it to the nurse immediately. During interview on 1/29/15, at 9:53 a.m. licensed practical nurse (LPN)-A was not aware of any bruising R37 had, but stated she would look at the Progress Notes. After consulting R37's medical record, LPN-A stated it appeared there was a bruise under R37's breast. LPN-A was not aware of the cause, and although she had not seen the bruise, she stated it could possibly have come from the mechanical lift sling. LPN-A confirmed R37's bruise was discovered on 1/27/15, according to the Progress Notes. During interview on 1/29/15, at 9:56 a.m.	F 226	2/2/15. Received word on 2/3/15 the no further action is necessary at this time. Staff involved in not reporting have been educated to investigate; report to the administrator, DON, and OHFC if origin is unknown; and document incident. Staff was educated on 2/17/15 at an All Staff In-service R/T reporting vulnerable adult issues immediately as well as the process to follow has been laminated and placed in all MARs with-in the facility for easy access to the procedure for reporting. The OHFC desktop icon has been placed on all computers in the facility for ease in submitting a report. To ensure that all reports are being filed in a timely manner, the DON will monitor daily any incident reports with the interdisciplinary team daily for one quarter and submit these findings for review and recommendations to the Quality Assurance Committee at the June 2015 meeting. Staff education was presented on 02/17/15 and F/U with those who did not attend by 2/27/15. Date corrected: 02/27/2015	

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F 226	Continued From page 6 registered nurse (RN)-A stated on 1/27/15, staff had reported R 37 had a large bruise under her left breast. RN-A stated no one was aware of how the bruise happened, there was no physical assessment including measuring of the bruise, no report of the bruise of unknown origin had been made to the state agency and/or administrator, and no investigation had been started. RN-A stated when a resident had a bruise/ injury of unknown origin, staff is instructed to ask the resident how it happened, assess the injury, and if the cause of the bruise or injury was unknown, a report would be filed with the state agency. RN-A stated she had talked to aides regarding R37's bruising and she felt it was due to the mechanical lift sling, however, RN-A stated she did not observe the bruising, nor did she document any investigation or interviews. During interview on 1/29/15, at 10:07 a.m. NA-C stated she gave R37 a bath on 1/27/15, and noticed the large bruise under the residents left breast and reported it to the nurse. During observation on 1/29/15, at 10:08 a.m. NA-C and LPN-A transferred R37 from the recliner to the wheelchair with the mechanical standing lift. RN-A was in the room to assess R37's bruising. RN-A used a paper measuring device to measure a dark, purple bruise on R37's lateral left breast, which measured 6 cm (centimeters) x 7 cm. RN-A stated the smaller bruising on R37's hand and lower arms were older bruises and she believed they came from R37 bumping the table. RN-A stated R37 was not cognitive enough to recall how the bruise happened. RN-A stated she believed the bruise was possibly caused from the mechanical lift sling, but could not be sure, and she was going to	F 226		

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F 226	Continued From page 7 report the bruise of unknown origin to the director of nursing (DON) so a report can be made to the state agency and an investigation could begin. During interview on 01/29/15, at 10:19 a.m. the DON stated she was not made aware of the bruising of unknown origin for R37. The DON stated staff are expected to complete incident reports on all bruises of unknown origin, and if the cause is not known staff are expected to immediately contact the administrator, DON, and make the initial report to the state agency, and then begin the investigation. During interview on 01/29/15, at 10:34 a.m. the administrator confirmed he was not aware of R37's bruise of unknown origin which was discovered on 1/27/15. The administrator stated all staff are expected to immediately report all bruising of unknown origin immediately to the administrator and state agency, and then investigate.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to promote dignity related to personal hygiene for 1 of 1 resident (R2) who was reviewed for dignity.	F 241	It is the policy of Minnewaska Lutheran Home that all employees treat our residents, their family and visitors, with kindness, respect, and dignity. Also, that care is provided in an environment that	2/27/15

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F 241	Continued From page 8 Findings include: R2's current care plan dated 12/16/14, identified R2 had diagnoses of hemiplegia affecting his left extremities, brain injury, and epilepsy. The careplan identified R2 had moderate cognitive impairment, required assistance from staff to complete all activities of daily living (ADL), including requiring extensive assistance grooming related to hemiparisis of his left side, and indicated he prefers to wear a clothing protector for all meals. During observation on 1/27/15, at 11:12 a.m. R2 was sitting in his wheelchair watching t.v. R2 had a tan brown food substance on the right side of his face running from the corner of his mouth, all the way to the bottom of his chin. Some of the tan brown food substance was dry and crusted onto R2's face, while the tan food substance continued to run down his chin area onto his shirt. The right upper chest area of R2's shirt had food on it which consisted of some cheerios, crumbs of toast, and the tan brown food substance that had been dripping down his chin. R2 continued to have food on his face and clothing until he went to the dining room for lunch. During observation on 1/28/15, at 12:31 p.m. R2 was done eating his lunch, which consisted of sweet and sour pork, mashed potatoes, squash, and strawberry sauce. R2 was trying to leave the dining room by peddling his wheelchair with his right foot, and using his right hand to wheel the wheelchair out of the dining room. Nursing assistant (NA)-E came into the dining room and assisted R2 to the activities room to talk to the activities director (AD). At 12:33 p.m. NA-E brought R2 to his room to watch t.v. At 12:36	F 241	maintains and enhances each resident's dignity and respect in full recognition of their individuality. The Director of Nursing or her designee is responsible to ensure that all residents are cared for in a manner and environment that enhances each resident's dignity. In the instance of resident R2, he has a medical history of traumatic brain injury many years ago resulting in (Lt.) sided hemi-paresis. As a result, he pockets food in his cheek which then runs out onto his face and clothing after he leaves the table. He has now been Care Planned to have oral cares after all meals. Staff are also to check face and shirt after meals to ensure that they are clean. Staff have been notified during shift change and education was provided on dignity at the All Staff In-service on 2/17/15. To ensure compliance, daily audits will be conducted for one week beginning 2/5/2015, then bi-weekly for 1 month or until 100% compliance is reached. Audits will be completed by the DON or designee. Results of audits will be brought to the Quality Assurance Committee at the June 2015 meeting for review and recommendation. Date corrected 02/27/2015	

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F 241	Continued From page 9 p.m. R2 continued to watch t.v. in his room and had a red, moist substance running down the left side of his face from the corner of his mouth, up to his mustache, and down his mid chin area. At 12:39 p.m. on 1/28/15, NA-E and NA-F entered R2's room and assisted R2 to his bed to use the bed pan and urinal. R2 was provided his call light and the aides left the room at 12:47 p.m. R2 continued to have the red substance on his face. At 1:23 p.m. NA-E and NA-F entered R2's room to assist the resident off the bedpan. After assisting R2 with pericare, NA-E and NA-F left the residents room at 1:30 p.m. R2 continued to have the a red, moist substance running down the left side of his face from the corner of his mouth to his mid chin area and along his mustache area. At 3:05 p.m. R2 was in his wheelchair and was sitting in the fireside room. R2 continued to have the red moist substance running down the left side of his face from the corner of his mouth to his mid chin area along his mustache area. During interview on 1/29/15, at 10:36 a.m. NA-E stated R2 always has food on his face after meals, and his shirt also gets dirty during meals at times. NA-E stated staff should be cleaning R2's face and clothing after meals and stated, "No, I do not feel that this [having food on his face and clothing] is dignified." During interview on 1/29/15, at 10:41 a.m. registered nurse (RN)-B stated R2 often had food stuck in his mustache and in the corners of his mouth. RN-B verified staff should be changing	F 241		

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F 241	Continued From page 10 his shirt and cleaning his face, and also stated it was not dignified for the resident to have food left on his face or clothes after dining. During interview on 1/29/15, at 11:01 a.m. director of nursing (DON) stated she has seen R2 with food on his face and clothing and she would expect staff to wipe his face, give him a drink of water, change his clothes if needed, and provide oral cares. The DON agreed it is not promoting the residents dignity to leave food on his mouth and clothing. Review of facility policy titled Courtesy dated 2/2014, directed staff to treat resident's, their family and visitor's, and fellow workers with kindness, respect and dignity.	F 241		
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, interview, and document review, the facility failed to follow the written care plan regarding fall interventions for 1 of 4 residents (R58) reviewed. Findings include: R58's quarterly Minimum Data Set (MDS) dated 1/13/15, identified R58 had severe cognitive impairment, required total staff assistance for all	F 282	It is the policy of Minnewaska Lutheran Home that "a comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs shall be developed for each resident" and is being followed by a qualified person. The care plan for R58 has been reviewed and stands as written to utilize the lower chair with the seat belt at all times others	2/27/15

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F 282	Continued From page 11 areas of daily living (ADL), and had sustained a fall in the facility. R58's care plan dated 1/21/15, identified R58 had a risk of falls and required assistance with transfers and mobility. The care plan instructed staff to reduce the risk of serious injury from falls to ensure resident was using the low wheel chair with seatbelt at all times while up, except when at meals. The care plan instructed staff to transfer the resident back into the low wheelchair with the seatbelt after R58 was done eating. During observation on 1/29/15, at 8:15 a.m. R58 was not transferred to the low wheel chair with the seat belt after breakfast, and was brought out in the tall wheel chair without a seat belt to sit in front of the bird aviary. No staff had been monitoring R58 in the tall wheel chair which was not equipped with the seat belt. During continuous observation, R58 remained in the tall wheel chair without a seat belt which was only to be used for meal time. Although several nursing staff had walked by R58, staff did not identify the resident was not in the low wheelchair with the safety belt attached as had been assessed to be used for fall prevention. At 8:58 a.m. NA-C propelled R85 to her room. During interview on 1/29/15, at 9:05 a.m. NA-H verified the tall wheel chair which R58 had been seated in unsupervised did not have a seat belt, and was only to be used when R58 was eating and in direct supervision of staff. During observation on 1/29/2015, at 11:06 a.m. NA-H placed R58 in front of the bird aviary while the resident was seated in the tall wheel chair without the seat belt, and walked away from the	F 282	then at mealtime. At mealtime, she will be placed in the tall chair without the seatbelt. All staff have been educated on the need to follow all residents' plan of care at an All Staff In-service held on 02/17/2015. One observational audit will be completed daily for one week, then bi-weekly for one week and then one time a month for one month by the DON or her designee to ensure the Care Plan is being followed by staff. Results of audits will be brought to the Quality Assurance Committee at the June 2015 meeting for review and recommendation. Date corrected: 02/27/2015	

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F 282	Continued From page 12 resident. During interview on 1/29/2015, at 11:12 a.m. registered nurse (RN)-A verified R58 had been unsupervised in the wheel chair which was not equipped with the seat belt for extended periods of time, and stated, "On a normal day, [R58] absolutely would not," be unsupervised in the tall wheel chair without the seatbelt. RN-A stated R58's care plan instructed staff to ensure the resident was in the low wheelchair with the seatbelt on at all times, except when eating. During interview on 1/28/2015, at 1:00 p.m. NA-I stated R58 utilized two different wheel chairs; one was higher and used for meals, and the other was lower to the ground and had a seat belt on it. NA-I stated R58 was a fall risk because she leaned forward in her wheelchair, which is why the resident was care planned to be in a low wheelchair with the seat belt. During interview on 1/29/2015, at 2:49 p.m. the director of nursing (DON) stated R58 was assessed to have the low to the ground wheel chair and a seat belt to prevent the resident from falling forward out of her wheelchair, and she would expect staff to follow R58's care planned. The facility policy titled Care Plans-Comprehensive dated 5/3/12, identified The comprehensive care plan has been designed to Enhance the optimal functioning of the resident.	F 282		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		2/27/15

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F 323	Continued From page 13 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to implement fall interventions as assessed for 1 of 3 residents (R58) reviewed for falls. Findings include: R58's quarterly Minimum Data Set (MDS) dated 1/13/15, identified R58 had severe cognitive impairment, required total staff assistance for all areas of daily living (ADL), and had sustained a fall in the facility. R58's care plan dated 1/21/15, identified R58 had a risk of falls and required assistance with transfers and mobility. The care plan instructed staff to reduce the risk of serious injury from falls to ensure resident was using the low wheel chair with seatbelt at all times while up, except when at meals. The care plan instructed staff to transfer the resident back into the low wheelchair with the seatbelt after R58 was done eating. R58's Nursing Progress Notes dated 12/27/14, indicated R58 had fallen out of the wheelchair on 12/25/14, however, did not receive any injury's. There was no further information regarding if the resident was wearing the seatbelt at the time, and if she was in the low wheelchair. The incident	F 323	It is the policy of Minnewaska Lutheran Home that "early fall and injury risk assessment and data gathering by licensed personnel shall help to establish appropriate and timely safety interventions, which will ensure the safety and well-being of the residents." It is the intent of the facility to ensure that all residents ' environments remain as free of accident hazards as possible, each receives adequate supervision and assistance devices to prevent accidents. R58's care plan has been reviewed and remains the same. All staff have been educated on the need to follow all residents' plan of care at an All Staff In-service held on 02/17/2015. Emphasis had been placed on following the care plan to ensure that adequate staff are involved in repositioning residents and that the care is being provided as outlined to ensure the safety and well being of the resident. This will be audited weekly for 2 weeks by the administrator or his designee while making walking rounds. This will provide opportunity to observe for a safe environment, resident satisfaction, and infection control. These audits will be	

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F 323	Continued From page 14 report of the fall dated 12/25/14, indicated staff was re-educated to ensure the armrests on the wheelchair were locked into place after completing cares. R58's assessment titled Observation Report dated 1/13/15, indicated the resident had a safety belt on when in the wheelchair, which was considered a restraint. According to the assessment, the resident leaned forward when she was in her wheelchair, and required the seatbelt to be on at all times or would, "Fall out of wheelchair on a daily basis." During observation on 1/28/2015, at 11:45 a.m. in the dining room R58 was leaning forward and was seated in a tall wheel chair which was slightly reclined. The wheelchair had a tabs alarm secured to the back of the wheel chair with Velcro, and a string that went from the alarm box on the tabs alarm to a clip attached to the right side of R58's sweater near her waist. At 11:47 a.m. nursing assistant (NA)-J instructed licensed practical nurse (LPN)-E not to remove R58 from the dinning area, so she could keep an eye on R58 until other staff came back. During multiple observations on 1/28/2015, from 12:56 p.m. to 2:28 p.m. and again at 3:19 p.m., R58 was seated in the low [to the floor] wheel chair with a tabs alarm secured to the back of the wheel chair by Velcro and the string from the alarm box to a clip attached to the center of R58's sweater near her neck. R58 had the seat belt fastened over her hips, and the resident was leaning forward in the wheelchair. During observation on 1/29/15, at 8:15 a.m. R58 was not transferred to the low wheel chair with	F 323	brought to the Quarterly Quality Assurance Committee at the June 2015 meeting for review and recommendations. Date corrected: 02/27/2015	

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F 323	Continued From page 15	F 323		

the seat belt after breakfast, and was brought out in the tall wheel chair without a seat belt to sit in front of the bird aviary. No staff had been monitoring R58 in the tall wheel chair which was not equipped with the seat belt. During continuous observation, R58 remained in the tall wheel chair without a seat belt which was only to be used for meal time. Although several nursing staff had walked by R58, staff did not identify the resident was not in the low wheelchair with the safety belt attached as had been assessed to be used for fall prevention. At 8:58 a.m. NA-C propelled R85 to her room.

During interview on 1/29/15, at 9:05 a.m. NA-H verified the tall wheel chair which R58 had been seated in unsupervised did not have a seat belt, and was only to be used when R58 was eating and in direct supervision of staff.

During observation on 1/29/2015, at 11:06 a.m. NA-H placed R58 in front of the bird aviary while the resident was seated in the tall wheel chair without the seat belt, and walked away from the resident.

During interview on 1/29/2015, at 11:12 a.m. registered nurse (RN)-A verified R58 had been unsupervised in the wheel chair which was not equipped with the seat belt for extended periods of time, and stated, "On a normal day, [R58] absolutely would not," be unsupervised in the tall wheel chair without the seatbelt.

During interview on 1/28/2015, at 1:00 p.m. NA-I stated R58 utilized two different wheel chairs; one was higher and used for meals, and the other was lower to the ground and had a seat belt on it. NA-I stated R58 was a fall risk because she

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F 323	Continued From page 16 leaned forward in her wheelchair, which is why the resident is to be in a low wheelchair with the seat belt. During interview on 1/29/2015, at 9:12 a.m. NA-H stated R58 had an alarm in use when seated in the tall wheel chair but did not have a seat belt. NA-H stated R58 was to be transferred to the low wheel chair with the seat belt as soon as she was done eating. During interview on 1/29/2015, at 9:33 a.m. LPN-A stated R58 had several fall interventions in place and included the use of two wheel chairs; one for use when eating, and one to be used at all other times. LPN-A stated R58 utilized the tall chair only for meals and was to be transferred to the low wheel chair with the seat belt when she was done eating. During interview on 1/29/2015, at 2:49 p.m. the director of nursing (DON) stated R58 was assessed to have the low to the ground wheel chair and a seat belt to prevent the resident from falling forward out of her wheelchair. The facility policy titled Resident Falls and Injury Monitoring Plan dated 10/11/10, identified residents who have risk factors for falling receive interventions to limit or eradicate the conditions that put them at fall risk.	F 323		
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	F 329		2/27/15

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F 329	Continued From page 17 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 review, the facility failed to identify clinical indications for use of an antipsychotic and antidepressant medication for 1 of 3 resident (R22) reviewed who received an antipsychotic and antidepressant medication. Findings include: The Annual Minimum Data Set (MDS) dated 10/22/14, identified R22 had no cognitive impairment and had no behaviors during the assessment period. Review of R22's current medication orders dated	F 329	It is the policy of the Minnewaska Lutheran home that "when antipsychotic medications are administered to a resident, it is our responsibility to ensure that ...the use of medications must be included in the resident's individual treatment plan and is based on the prescribing physician's diagnosis and the functional assessment; that documentation in the resident's individual treatment plan includes a description in observable and measurable terms of the symptoms and behaviors that the medication is to alleviate; and a data collection method to monitor and	

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F 329	Continued From page 18 1/2015, identified R22 received Remeron (an antidepressant medication), with a start date of 8/23/14, 15 milligrams daily (mg) daily, and Zyprexa (an antipsychotic medication), with a start date of 12/12/14, 2.5 mg daily. Review of R22's medical record lacked documentation of identified target behaviors justifying use for the Remeron and Zyprexa or any behavioral interventions which may be required by staff. During observation on 1/28/2015, at 11:55 a.m. R22 was laying on top of the covers in bed with the curtains pulled and lights off. During observation on 1/28/2015, at 6:31 p.m. R22 was seated in the dining room eating with four other male residents. R22 engaged in conversation with the other male residents seated at his table,completed his meal, and stacked the dishes together. During interview on 01/29/2015, at 10:26 a.m. nursing assistant (NA)-C stated R22 had, "Occasional" behaviors of refusal to get washed up. During interview on 1/29/2015, at 10:52 a.m. registered nurse (RN)-A stated R22 previously had behaviors of refusing to wear a code alert (a device to alert staff of a resident leaving), however, R22 no longer required the code alert bracelet because he didn't try to exit the building without staff knowledge. RN-A verified R22's record lacked target behaviors justifying the use of Zyprexa and Remeron, nor any behavioral interventions for staff to try for any behaviors determined, and RN-A stated R22 did not have a	F 329	measure changes in symptoms and behaviors that are to be alleviated." The DON or her designee is responsible to ensure that there is adequate monitoring of behavioral symptoms which would require the continued use of antipsychotic medications. R1's physician's orders were reviewed. R1 has been medicated with Remeron 15 mg daily for the diagnoses of depressive disorder. Per resident's primary care physician, he was started on Zyprexa 2.5 mg q HS on 12/12/2014 for behaviors that had occurred for at least 10 days of swearing at staff for having to let staff know he was leaving the facility, cutting off his code alert and being resistive with cares. Family had stated that he was on medication for these types of behaviors and would like the doctor to know what is happening to see if he could be put back on them. Refused to let the nurses put the Code Alert back on so currently was not being monitored with it. Behavior monitoring was initiated on 1/1/2015, monitoring for aggression and refusal of cares. Also, a weekly nurse's note has been added for documentation of behaviors and interventions that have been tried and were successful. Monthly medication review will be conducted on all residents residing at Minnewaska Lutheran Home by Consultant Pharmacists' to review medication regimen and documentation that supports the clinical indication for continued use of antipsychotic drugs. The pharmacy consultant reviews will be followed up by the Case Managers and	

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F 329	Continued From page 19 proper diagnosis for the use of Zyprexa or Remeron. During interview on 1/29/2015, at 1:48 p.m. the director of nursing (DON) verified the expected protocol of the use of antipsychotic medication included identifying target behaviors and interventions, along with ongoing monitoring of the target behaviors by tracking the episodes of any behaviors. During a phone interview on 1/29/15, at 4:30 p.m. the facility consulting pharmacist stated target behaviors, interventions, justification, and documentation should be in place for use of Remeron and Zyprexa, and stated especially for those residents receiving these medications, "Not specifically for psychosis." The undated facility policy titled Psychotropic Medication Review identified Staff must consider and document targeted symptoms and behaviors of concern.	F 329	needed recommendations are sent to the primary care physician for follow-up orders. Audits will be completed weekly on 10% of the resident's records in accordance with their Resident Care Conference schedule for three months to ensure that there is documentation supporting the clinical indications for the use of any antipsychotic medications. The results of these audits will be presented to the quarterly Quality Assurance Committee at the June 2015 meeting for recommendations of the committee for further auditing schedule. Date corrected 02/27/2015	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		2/27/15

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F 428	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility consulting pharmacist failed to ensure 1 of 3 residents (R22), who were taking an antipsychotic and antidepressant medication, had justification for use. Findings include: The Annual Minimum Data Set (MDS) dated 10/22/14, identified R22 had no cognitive impairment and had no behaviors during the assessment period. Review of R22's current medication orders dated 1/2015, identified R22 received Remeron (an antidepressant medication), with a start date of 8/23/14, 15 milligrams daily (mg) daily, and Zyprexa (an antipsychotic medication), with a start date of 12/12/15, 2.5 mg daily. Review of R22's medical record lacked documentation of identified target behaviors justifying use for the Remeron or Zyprexa. Review of the facility form for the last year titled Pharmacist's Medication Regimen Review, identified monthly documentation by the consulting pharmacist review of R22's medication, however, there was no pharmacist recommendations regarding target behaviors, behavioral interventions, or indications for use of the Remeron or Zyprexa. During observation on 1/28/2015, at 11:55 a.m. R22 was laying on top of the covers in bed with the curtains pulled and lights off.	F 428	It is the policy of Minnewaska Lutheran home that "the consultant pharmacist shall conduct a chart review of resident's drug regimen on a monthly basis for the purpose of identifying appropriate drug utilization and compliance with federal and state drug review regulations." The DON or her designee is responsible to ensure that the pharmacist reports any irregularities to the attending physician, the director of nursing and these reports must be acted upon. R22's pharmacy consultant note dated 01/05/2015, "recent increase in depressive symptoms-no indication to reduce Remeron. Zyprexa restarted 12/14-will monitor. Appears to tolerate." Pharmacy Consultant note dated 02/09/2015 indicates "behaviors not easily redirected appears improved on Zyprexa. Non-pharmacological interventions appear to be helping. Will plan to address potential reduction in near future (approx. June 2015)." The DON or her designee will review the appropriateness of current medication regimen of all residents and refer any concerns to the primary physician and/or consultant pharmacist for review. The DON will review recommendations and physician's response to those recommendations. Audits will be performed on 10% of the recommendations for three months to ensure that adequate justification is provided if the physician does not concur with the pharmacist's recommendations.	

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F 428	Continued From page 21 During observation on 1/28/2015, at 6:31 p.m. R22 had been seated in the dining room, eating with four other male residents. R22 engaged conversation with the other male residents seated at his table, completed his meal, and stacked the dishes together. During interview on 01/29/2015, at 10:26 a.m. nursing assistant (NA)-C stated R22 had, "Occasional," behavior of refusal to get washed up. During interview on 1/29/2015, at 10:52 a.m. registered nurse (RN)-A stated R22 previously had behaviors of refusing to wear a code alert (a device to alert staff of a resident leaving), however, R22 no longer required the code alert bracelet because he no longer tried to exit the building without staff knowledge. RN-A verified R22's record lacked target behaviors for the Zyprexa and Remeron, did not have any behavioral interventions for staff to try for any behaviors determined, and RN-A stated R22 did not have a proper diagnosis for the use of Zyprexa or Remeron. During interview on 1/29/2015, at 1:48 p.m. the director of nursing (DON) verified the expected protocol for the use of antipsychotic medication included identifying target behaviors and interventions, along with ongoing monitoring of the target behaviors by tracking the episodes of any behaviors. During a phone interview on 1/29/15, at 4:30 p.m. the facility consulting pharmacist stated target behaviors, interventions, justification for use, and documentation should be in place for use of Remeron and Zyprexa, and stated especially for	F 428	The results of the audits will be presented at the quarterly Quality Assurance Committee at the June 2015 meeting and will proceed according to recommendations of the committee. Date corrected 02/27/2015	

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	245537	A. BUILDING _____ B. WING _____	01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEWASKA COMMUNITY HEALTH SERVICES	605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381

(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 428	Continued From page 22 those residents receiving these medications, "Not specifically for psychosis." The undated facility policy titled Psychotropic Medication Review identified staff must consider and document targeted symptoms and behaviors of concern.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 431		2/27/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEWASKA COMMUNITY HEALTH SERVICES	605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381

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F 431	Continued From page 23 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and, document review, the facility failed to ensure insulin pens were dated when opened to ensure medication was not expired for 1 of 1 resident, R48, who was being administered insulin which had not been dated when opened. Findings include: On 01/27/15, at 2:09 p.m. the medication cart for the D-wing was observed with licensed practical nurse (LPN)-A. There was a half full Humalog insulin flex pen for R48 which had no date on when it was opened. The insulin pen had a pharmacy label with a delivery date to the facility of 10/06/14. LPN -A confirmed staff were expected to date all insulin pens when they are opened to ensure residents are not receiving insulin which is expired, and LPN-A was unable to determine when the insulin pen had been opened for R48. R48's January 2015, Medication Administration Record (MAR) indicated R48 was to receive the Humalog insulin based on a sliding scale of his blood glucose level, and had received the undated Humalog insulin on all but three evenings. During interview on 01/27/15, at 2:19 p.m. the director of nursing (DON) stated her expectation	F 431	It is the policy of Minnewaska Lutheran Home that all multi-dose vials, staff will "label the medication vial with the date and time opened, the initials of the person opening the vial, and the expiration date of the vial, not to exceed 28 days, unless recommendations differ from the manufacturer." The DON or her designee is responsible to ensure that drugs and biological used in the facility are labeled in accordance with currently accepted professional principles, including the appropriate accessory and cautionary instructions, and the expiration date when applicable. All nursing staff have been educated on the policy of initialing and dating all multi-dose bottles and vial once opened. A review was completed by the Pharmacy Consultants on 02/09/2015 and discussion was had in regards to staff initialing and dating multi-dose vials once opened. The Pharmacy Consultants will provide education to all nursing staff on 03/12/2015 related to medication administration. Audits will be completed by the DON or her designee on all medication carts to ensure that proper labeling has occurred on all multi-dose bottles and vials one time per week for 2 weeks then monthly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEWASKA COMMUNITY HEALTH SERVICES	605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381

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F 431	Continued From page 24 was all insulin pens were to be dated upon opening as the expiration date of insulin is based off the open date, and nurses receive education upon hire and yearly regarding the facility policy for dating insulin and other multi-use pens/vials. A facility policy titled Labeling of Medications dated 6/22/09, instructed staff to ensure all medications maintained in the facility were properly labeled in accordance with state and federal regulations, and facility nurses should date all multi-dose medications, including insulin, when opened. The facility provided a guide titled, Medication Expiration Dating from Consultant Pharmacists Inc dated 10/08, which indicated the expiration dating of opened Humalog PEN expired 28 days after opening. In addition, the facility also provided a undated guide titled Medication to date when opened, which directed nursing staff to date all insulin upon opening.	F 431	for 2 months . Audits will also be completed by the Pharmacy Consultants monthly when in the facility. The results of these audits will be presented to the quarterly Quality Assurance Committee at the June 2015 meeting for recommendations of the committee for further auditing schedule. Date corrected 02/27/2015	
F 458 SS=E	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure the single resident rooms on the A-wing of the facility had at least 100 square feet of useable floor space for	F 458	Waiver Request Waiver requested: in rooms 24.25.26, 27,28,29, 30, 31,31, 33,34, 35, and 36 are 95.68 to 96.07 square feet of usable space and do not meet the minimum	~~2/27/15~~

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245537	A. BUILDING _____ B. WING _____	01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEWASKA COMMUNITY HEALTH SERVICES	605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381

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F 458	Continued From page 25 13 of 15 rooms. This affected 12 of 12 residents (R54, R70, R39, R32, R15, R41, R67, R14, R59, R33, R3, R61) who resided in the rooms. Findings include: During tour of the A-wing on 1/28/15, at 1:30 p.m. the resident rooms 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35 and 36 were observed to not have at least 100 square feet of useable floor space. On 1/28/15, at 1:37 p.m. R54 reported there was plenty of space to get around in the room with the walker, and had no concerns with the size of the room. On 1/28/15, at 1:40 p.m. R15 stated there could be more space in her room and reported it is hard moving around in the room with the wheelchair, however, she did not want to switch rooms and had not contacted anyone in the facility regarding switching rooms. On 1/28/15, at 1:43 p.m. R39 stated she had no issues with the room size and was able to move around with no difficulty. On 1/28/15, at 1:45 p.m. R32 stated he was completely satisfied with his room, had no complaints. On 1/28/15, at 1:55 p.m. R70 stated she had no difficulties getting around her room and was satisfied. All rooms were noted to all be clean, orderly, and decorated . When interviewed on 1/28/15, at 2:00 p.m. the	F 458	requirements of at least 100 square feet of usable space. Formally complying bedrooms were reduced in area to accommodate expanded toilet rooms. A previous similar waiver was requested.	

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	245537	A. BUILDING _____ B. WING _____	01/29/2015

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MINNEWASKA COMMUNITY HEALTH SERVICES	605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381

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F 458	Continued From page 26 housekeeping services employee stated the rooms on the A-wing were smaller, but was still able to clean the space adequately with no problems. When interviewed on 1/28/15, at 2:15 p.m. nursing assistant (NA)-A stated the rooms are smaller on the A-wing, however, there were no difficulties taking care of residents due to the room sizes, even when mechanical lifts are utilized. During interview on 1/28/15, at 2:35 p.m. the facility environmental services director (ESD) stated the single rooms on the A-wing were less than the required 100 square feet of useable floor space, and the faciltiy would be applying for a room wavier. When interviewed on 1/29/15, at 9:05 a.m. the administrator confirmed the rooms on the A-wing continue to have less than 100 square feet of usable space and would be applying for the waiver again.	F 458		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245537	A. BUILDING **01 - 01 - 1960 BUILDING AND ADDITIONS** B. WING _____	**01/26/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEWASKA COMMUNITY HEALTH SERVIC	**605 MAIN STREET. PO BOX 40 STARBUCK, MN 56381**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on January 26, 2015. At the time of this survey, Building 01 of Minnewaska Community Health Services Nursing Home was found to be in 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 Occupancies. Building 01 of Minnewaska Community Health Services Nursing Home is a one-story building with no basement, and is fully fire sprinkler protected throughout. The original 1960 building along with the 1968 and 1972 additions were determined to be of Type II(111) construction. The 1988 and 1996 building additions were determined to be of Type V(111) construction. The 2000 building addition was determined to be of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 65 beds and had a census of 60 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET as evidenced by:	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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245537	A. BUILDING **02 - 02 - 2004 ADDITIONS** B. WING _____	**01/26/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEWASKA COMMUNITY HEALTH SERVICI	**605 MAIN STREET. PO BOX 40 STARBUCK, MN 56381**

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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, on January 26,2015. At the time of this survey, Building 02 of Minnewaska Community Health Services Nursing Home was found to be in 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 18 New Health Care Occupancies. Building 02 of Minnewaska Community Health Services Nursing Home consists of the 2004 building addition, and is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type V(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 65 beds and had a census of 60 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET as evidenced by:	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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
February 13, 2015

Mr. Christopher Knoll, Administrator
Minnewaska Community Health Services
605 Main Street, PO Box 40
Starbuck, Minnesota 56381

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5537026

Dear Mr. Knoll:

The above facility was surveyed on January 26, 2015 through January 29, 2015 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.

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

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

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Jessica Sellner at (320) 223-7343 or email: jessica.sellner@state.mn.us.

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.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

5537s15licensing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00477	A. BUILDING: _____ B. WING _____	01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEWASKA COMMUNITY HEALTH SERVICE	605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00477	A. BUILDING: _____ B. WING _____	01/29/2015

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MINNEWASKA COMMUNITY HEALTH SERVICE	605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On January 26th, 27th, 28th and 29th 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced	2 302		2/27/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 302	Continued From page 3 by: Based on interview and document review, the facility failed to provide the required Alzheimer's training for 1 of 4 nursing assistants (NA-D) and for 2 of 2 licensed practical nurses (LPN-C, LPN-D) who provided direct care services. In addition, the facility failed to provide consumers (family and/ or residents) with written information regarding the Alzheimer's training program. This had the potential to affect all 60 residents who resided in the facility and their families. Findings include: LPN-D was hired on 10/13/14. The employee record lacked evidence of recieving the required Alzheimer's training. NA-D was hired on 10/27/14. The employee record lacked evidence of recieving the required Alzheimer's training. LPN-C was hired on 10/16/14. The employee record lacked evidence of recieving the required Alzheimer's training. During interview on 1/27/15, at 3:11 p.m. the director of nursing (DON) verified the above staff had not received the required Alzheimer's training. During interview on 1/27/15, at 3:18 p.m. SSD verified consumers were not provided information regarding the facility staff Alzheimer's training program. The SSD stated the families of residents admitted to the (Alzheimer's) dementia unit are only informed of the criteria to be cared for on that unit, and are not providing any information on staff training.	2 302	Acknowledged...	

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2 302	Continued From page 4 A policy regarding the faciltiy Alzheimers training was requested but not provided. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) could develop and implement policies and procedures related to the required Alzheimer's training program requirements. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days.	2 302		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow the written care plan regarding fall interventions for 1 of 4 residents (R58) reviewed. Findings include: R58's quarterly Minimum Data Set (MDS) dated 1/13/15, identified R58 had severe cognitive impairment, required total staff assistance for all areas of daily living (ADL), and had sustained a fall in the facility.	2 565	Acknowledged	2/27/15

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2 565	Continued From page 5 R58's care plan dated 1/21/15, identified R58 had a risk of falls and required assistance with transfers and mobility. The care plan instructed staff to reduce the risk of serious injury from falls to ensure resident was using the low wheel chair with seatbelt at all times while up, except when at meals. The care plan instructed staff to transfer the resident back into the low wheelchair with the seatbelt after R58 was done eating. During observation on 1/29/15, at 8:15 a.m. R58 was not transferred to the low wheel chair with the seat belt after breakfast, and was brought out in the tall wheel chair without a seat belt to sit in front of the bird aviary. No staff had been monitoring R58 in the tall wheel chair which was not equipped with the seat belt. During continuous observation, R58 remained in the tall wheel chair without a seat belt which was only to be used for meal time. Although several nursing staff had walked by R58, staff did not identify the resident was not in the low wheelchair with the safety belt attached as had been assessed to be used for fall prevention. At 8:58 a.m. NA-C propelled R85 to her room. During interview on 1/29/15, at 9:05 a.m. NA-H verified the tall wheel chair which R58 had been seated in unsupervised did not have a seat belt, and was only to be used when R58 was eating and in direct supervision of staff. During observation on 1/29/2015, at 11:06 a.m. NA-H placed R58 in front of the bird aviary while the resident was seated in the tall wheel chair without the seat belt, and walked away from the resident. During interview on 1/29/2015, at 11:12 a.m.	2 565		

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2 565	Continued From page 6 registered nurse (RN)-A verified R58 had been unsupervised in the wheel chair which was not equipped with the seat belt for extended periods of time, and stated, "On a normal day, [R58] absolutely would not," be unsupervised in the tall wheel chair without the seatbelt. RN-A stated R58's care plan instructed staff to ensure the resident was in the low wheelchair with the seatbelt on at all times, except when eating. During interview on 1/28/2015, at 1:00 p.m. NA-I stated R58 utilized two different wheel chairs; one was higher and used for meals, and the other was lower to the ground and had a seat belt on it. NA-I stated R58 was a fall risk because she leaned forward in her wheelchair, which is why the resident was care planned to be in a low wheelchair with the seat belt. During interview on 1/29/2015, at 2:49 p.m. the director of nursing (DON) stated R58 was assessed to have the low to the ground wheel chair and a seat belt to prevent the resident from falling forward out of her wheelchair, and she would expect staff to follow R58's care planned. The facility policy titled Care Plans-Comprehensive dated 5/3/12, identified The comprehensive care plan has been designed to Enhance the optimal functioning of the resident. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could implement policies and procedures related to ensuring staff implement resident care plans. The quality assessment and assurance committee could perform random audits to ensure compliance.	2 565		

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2 565	Continued From page 7 TIME PERIOD FOR CORRECTION: Twenty (21) days.	2 565		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to employee Tuberculosis (TB) Screening and Tuberculin Skin Testing (TST) and medical evaluations were completed for 4 of 5 employees (LPN-D, NA-D, DA-A and DA-B) before resident contact.	21426	Acknowledged	2/27/15

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21426	Continued From page 8 Findings include: A review of licensed practical nurse (LPN)-D employee file indicated a hire date of 10/13/14. The Employee Tuberculosis Screening was completed 10/8/14, along with the first step TST. There was no evidence a second step TST had been administered. A review of nursing assistant (NA)-D employee file indicated a hire date of 10/27/14. The Employee Tuberculosis Screening was completed 10/20/14, along with the first step TST. There was no evidence a second step TST had been administered. A review of dietary associate (DA)-A employee file indicated a hire date of 12/13/14. The Employee Tuberculosis Screening was completed 12/2/14, along with the first step TST. There was no evidence a second step TST had been administered. A review of dietary associate (DA)-B employee file indicated a hire date of 11/10/14. The Employee Tuberculosis Screening was completed 11/7/14, along with the first step TST. There was no evidence a second step TST had been administered. During interview on 1/29/2015 at 8:33 a.m. director of nursing (DON) stated LPN-D, NA-D, DA-A and DA-B did not receive the second step TST. The DON stated she knew this was a problem [employees receiving the second step TST], and believed it was due to staff not keeping track of the dates to get the second step TST completed.	21426		

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21426	Continued From page 9 During interview on 1/29/2015, at 11:11 a.m. registered nurse (RN)-B stated new staff can't start work until they have had the 1st step TST, and 2-3 weeks later the new hire is required to receive the second step TST. The facility policy titled Minnewaska Community Health Services Tuberculosis Control Plan/Risk Assessment form dated 1/7/14, indicated all new employees and volunteers will have an initial two-step mantoux [TST]. The facility policy titled Tuberculosis Screening of Employees/Volunteers Policy dated 1/4/14, indicated upon employment, a second step TST needed to be administered 14-21 days after the first step. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) could develop and implement policies and procedures related to completing employee Tuberculosis screening. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days.	21426		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service	21530		2/27/15

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21530	Continued From page 10 Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility consulting pharmacist failed to ensure 1 of 3 residents (R22), who were taking an antipsychotic and antidepressant medication,	21530	Acknowledged	

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21530	Continued From page 11 had justification for use. Findings include: The Annual Minimum Data Set (MDS) dated 10/22/14, identified R22 had no cognitive impairment and had no behaviors during the assessment period. Review of R22's current medication orders dated 1/2015, identified R22 received Remeron (an antidepressant medication), with a start date of 8/23/14, 15 milligrams daily (mg) daily, and Zyprexa (an antipsychotic medication), with a start date of 12/12/15, 2.5 mg daily. Review of R22's medical record lacked documentation of identified target behaviors justifying use for the Remeron or Zyprexa. Review of the facility form for the last year titled Pharmacist's Medication Regimen Review, identified monthly documentation by the consulting pharmacist review of R22's medication, however, there was no pharmacist recommendations regarding target behaviors, behavioral interventions, or indications for use of the Remeron or Zyprexa. During observation on 1/28/2015, at 11:55 a.m. R22 was laying on top of the covers in bed with the curtains pulled and lights off. During observation on 1/28/2015, at 6:31 p.m. R22 had been seated in the dining room, eating with four other male residents. R22 engaged conversation with the other male residents seated at his table, completed his meal, and stacked the dishes together.	21530		

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21530	Continued From page 12 During interview on 01/29/2015, at 10:26 a.m. nursing assistant (NA)-C stated R22 had, "Occasional," behavior of refusal to get washed up. During interview on 1/29/2015, at 10:52 a.m. registered nurse (RN)-A stated R22 previously had behaviors of refusing to wear a code alert (a device to alert staff of a resident leaving), however, R22 no longer required the code alert bracelet because he no longer tried to exit the building without staff knowledge. RN-A verified R22's record lacked target behaviors for the Zyprexa and Remeron, did not have any behavioral interventions for staff to try for any behaviors determined, and RN-A stated R22 did not have a proper diagnosis for the use of Zyprexa or Remeron. During interview on 1/29/2015, at 1:48 p.m. the director of nursing (DON) verified the expected protocol for the use of antipsychotic medication included identifying target behaviors and interventions, along with ongoing monitoring of the target behaviors by tracking the episodes of any behaviors. During a phone interview on 1/29/15, at 4:30 p.m. the facility consulting pharmacist stated target behaviors, interventions, justification for use, and documentation should be in place for use of Remeron and Zyprexa, and stated especially for those residents receiving these medications, "Not specifically for psychosis." The undated facility policy titled Psychotropic Medication Review identified staff must consider and document targeted symptoms and behaviors of concern.	21530		

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21530	Continued From page 13 SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures related to consulting pharmacist reporting irregularities. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not	21535		2/27/15

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21535	Continued From page 14 subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to identify clinical indications for use of an antipsychotic and antidepressant medication for 1 of 3 resident (R22) reviewed who received an antipsychotic and antidepressant medication. Findings include: The Annual Minimum Data Set (MDS) dated 10/22/14, identified R22 had no cognitive impairment and had no behaviors during the assessment period. Review of R22's current medication orders dated 1/2015, identified R22 received Remeron (an antidepressant medication), with a start date of 8/23/14, 15 milligrams daily (mg) daily, and Zyprexa (an antipsychotic medication), with a start date of 12/12/14, 2.5 mg daily. Review of R22's medical record lacked documentation of identified target behaviors justifying use for the Remeron and Zyprexa or any behavioral interventions which may be required by staff. During observation on 1/28/2015, at 11:55 a.m. R22 was laying on top of the covers in bed with the curtains pulled and lights off. During observation on 1/28/2015, at 6:31 p.m. R22 was seated in the dining room eating with four other male residents. R22 engaged in conversation with the other male residents seated	21535	Acknowledged	

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21535	Continued From page 15 at his table,completed his meal, and stacked the dishes together. During interview on 01/29/2015, at 10:26 a.m. nursing assistant (NA)-C stated R22 had, "Occasional" behaviors of refusal to get washed up. During interview on 1/29/2015, at 10:52 a.m. registered nurse (RN)-A stated R22 previously had behaviors of refusing to wear a code alert (a device to alert staff of a resident leaving), however, R22 no longer required the code alert bracelet because he didn't try to exit the building without staff knowledge. RN-A verified R22's record lacked target behaviors justifying the use of Zyprexa and Remeron, nor any behavioral interventions for staff to try for any behaviors determined, and RN-A stated R22 did not have a proper diagnosis for the use of Zyprexa or Remeron. During interview on 1/29/2015, at 1:48 p.m. the director of nursing (DON) verified the expected protocol of the use of antipsychotic medication included identifying target behaviors and interventions, along with ongoing monitoring of the target behaviors by tracking the episodes of any behaviors. During a phone interview on 1/29/15, at 4:30 p.m. the facility consulting pharmacist stated target behaviors, interventions, justification, and documentation should be in place for use of Remeron and Zyprexa, and stated especially for those residents receiving these medications, "Not specifically for psychosis." The undated facility policy titled Psychotropic Medication Review identified Staff must consider	21535		

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21535	Continued From page 16 and document targeted symptoms and behaviors of concern. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures related to continued use of antipsychotic use in the elderly. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days.	21535		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview, and, document review, the facility failed to ensure insulin pens were dated when opened to ensure medication was not expired for 1 of 1 resident, R48, who was being administered insulin which had not been dated when opened. Findings include: On 01/27/15, at 2:09 p.m. the medication cart for the D-wing was observed with licensed practical nurse (LPN)-A. There was a half full Humalog insulin flex pen for R48 which had no date on when it was opened. The insulin pen had a pharmacy label with a delivery date to the facility of 10/06/14. LPN -A confirmed staff were	21620	Acknowledged	2/27/15

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21620	Continued From page 17 expected to date all insulin pens when they are opened to ensure residents are not receiving insulin which is expired, and LPN-A was unable to determine when the insulin pen had been opened for R48. R48's January 2015, Medication Administration Record (MAR) indicated R48 was to receive the Humalog insulin based on a sliding scale of his blood glucose level, and had received the undated Humalog insulin on all but three evenings. During interview on 01/27/15, at 2:19 p.m. the director of nursing (DON) stated her expectation was all insulin pens were to be dated upon opening as the expiration date of insulin is based off the open date, and nurses receive education upon hire and yearly regarding the facility policy for dating insulin and other multi-use pens/vials. A facility policy titled Labeling of Medications dated 6/22/09, instructed staff to ensure all medications maintained in the facility were properly labeled in accordance with state and federal regulations, and facility nurses should date all multi-dose medications, including insulin, when opened. The facility provided a guide titled, Medication Expiration Dating from Consultant Pharmacists Inc dated 10/08, which indicated the expiration dating of opened Humalog PEN expired 28 days after opening. In addition, the facility also provided a undated guide titled Medication to date when opened, which directed nursing staff to date all insulin upon opening.	21620		

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21620	Continued From page 18 SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) could develop and implement policies and procedures related to labeling medications when opened when necessary such as insulin. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days.	21620		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to promote dignity related to personal hygiene for 1 of 1 resident (R2) who was reviewed for dignity. Findings include: R2's current care plan dated 12/16/14, identified R2 had diagnoses of hemiplegia affecting his left extremities, brain injury, and epilepsy. The careplan identified R2 had moderate cognitive impairment, required assistance from staff to complete all activities of daily living (ADL), including requiring extensive assistance grooming related to hemiparisis of his left side, and	21805	Acknowledged	2/27/15

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21805	Continued From page 19 indicated he prefers to wear a clothing protector for all meals. During observation on 1/27/15, at 11:12 a.m. R2 was sitting in his wheelchair watching t.v. R2 had a tan brown food substance on the right side of his face running from the corner of his mouth, all the way to the bottom of his chin. Some of the tan brown food substance was dry and crusted onto R2's face, while the tan food substance continued to run down his chin area onto his shirt. The right upper chest area of R2's shirt had food on it which consisted of some cheerios, crumbs of toast, and the tan brown food substance that had been dripping down his chin. R2 continued to have food on his face and clothing until he went to the dining room for lunch. During observation on 1/28/15, at 12:31 p.m. R2 was done eating his lunch, which consisted of sweet and sour pork, mashed potatoes, squash, and strawberry sauce. R2 was trying to leave the dining room by peddling his wheelchair with his right foot, and using his right hand to wheel the wheelchair out of the dining room. Nursing assistant (NA)-E came into the dining room and assisted R2 to the activities room to talk to the activities director (AD). At 12:33 p.m. NA-E brought R2 to his room to watch t.v. At 12:36 p.m. R2 continued to watch t.v. in his room and had a red, moist substance running down the left side of his face from the corner of his mouth, up to his mustache, and down his mid chin area. At 12:39 p.m. on 1/28/15, NA-E and NA-F entered R2's room and assisted R2 to his bed to use the bed pan and urinal. R2 was provided his call light and the aides left the room at 12:47 p.m. R2 continued to have the red substance on his face.	21805		

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21805	Continued From page 20 At 1:23 p.m. NA-E and NA-F entered R2's room to assist the resident off the bedpan. After assisting R2 with pericare, NA-E and NA-F left the residents room at 1:30 p.m. R2 continued to have the a red, moist substance running down the left side of his face from the corner of his mouth to his mid chin area and along his mustache area. At 3:05 p.m. R2 was in his wheelchair and was sitting in the fireside room. R2 continued to have the red moist substance running down the left side of his face from the corner of his mouth to his mid chin area along his mustache area. During interview on 1/29/15, at 10:36 a.m. NA-E stated R2 always has food on his face after meals, and his shirt also gets dirty during meals at times. NA-E stated staff should be cleaning R2's face and clothing after meals and stated, "No, I do not feel that this [having food on his face and clothing] is dignified." During interview on 1/29/15, at 10:41 a.m. registered nurse (RN)-B stated R2 often had food stuck in his mustache and in the corners of his mouth. RN-B verified staff should be changing his shirt and cleaning his face, and also stated it was not dignified for the resident to have food left on his face or clothes after dining. During interview on 1/29/15, at 11:01 a.m. director of nursing (DON) stated she has seen R2 with food on his face and clothing and she would expect staff to wipe his face, give him a drink of water, change his clothes if needed, and provide oral cares. The DON agreed it is not promoting the residents dignity to leave food on his mouth and clothing.	21805		

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21805	Continued From page 21 Review of facility policy titled Courtesy dated 2/2014, directed staff to treat resident's, their family and visitor's, and fellow workers with kindness, respect and dignity. SUGGESTED METHOD OF CORRECTION: The DON or designee could educate staff on providing dignified care to residents. The DON or designee could then interview residents routinely to ensure residents feel their dignity and respect are being maintained. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21805		
21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under	21990		2/27/15

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21990	Continued From page 22 section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to immediately report to the administrator and state agency (SA), and complete a thorough investigation, for 1 of 1 resident (R37) with a bruise of unknown origin. Findings include: R37's annual Minimum Data Set (MDS) dated 11/6/14, identified R37 had severely cognitive impairment, required extensive staff assistance for all areas of daily living (ADL), and required a mechanical standing lift and assistance of two staff for all transfers R37's care area assessment (CAA) dated 11/12/14, identified R37 had diagnoses including dementia with Lewy bodies and progressing Parkinson's Disease, and R37 was dependent on staff to anticipate needs and rarely/never made decisions regarding daily tasks of life. Review of R37 Progress Notes dated 1/27/15, indicated R37 had large bruises under left breast, left shoulder, and hand. During interview on 1/29/15, at 9:48 a.m. nursing assistant (NA)-B stated the only bruise she was aware that R37 had was a bruise on her left hand which was not new, and NA-B thought it came from the resident bumping the table. NA-B not aware of any other bruising R37 had, however, if she noted bruising she would report it to the nurse immediately.	21990	Acknowledged	

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21990	Continued From page 23 During interview on 1/29/15, at 9:53 a.m. licensed practical nurse (LPN)-A was not aware of any bruising R37 had, but stated she would look at the Progress Notes. After consulting R37's medical record, LPN-A stated it appeared there was a bruise under R37's breast. LPN-A was not aware of the cause, and although she had not seen the bruise, she stated it could possibly have come from the mechanical lift sling. LPN-A confirmed R37's bruise was discovered on 1/27/15, according to the Progress Notes. During interview on 1/29/15, at 9:56 a.m. registered nurse (RN)-A stated on 1/27/15, staff had reported R 37 had a large bruise under her left breast. RN-A stated no one was aware of how the bruise happened, there was no physical assessment including measuring of the bruise, no report of the bruise of unknown origin had been made to the state agency and/or administrator, and no investigation had been started. RN-A stated when a resident had a bruise/ injury of unknown origin, staff is instructed to ask the resident how it happened, assess the injury, and if the cause of the bruise or injury was unknown, a report would be filed with the state agency. RN-A stated she had talked to aides regarding R37's bruising and she felt it was due to the mechanical lift sling, however, RN-A stated she did not observe the bruising, nor did she document any investigation or interviews. During interview on 1/29/15, at 10:07 a.m. NA-C stated she gave R37 a bath on 1/27/15, and noticed the large bruise under the residents left breast and reported it to the nurse. During observation on 1/29/15, at 10:08 a.m. NA-C and LPN-A transferred R37 from the recliner to the wheelchair with the mechanical	21990		

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21990	Continued From page 24	21990		

standing lift. RN-A was in the room to assess R37's bruising. RN-A used a paper measuring device to measure a dark, purple bruise on R37's lateral left breast, which measured 6 cm (centimeters) x 7 cm. RN-A stated the smaller bruising on R37's hand and lower arms were older bruises and she believed they came from R37 bumping the table. RN-A stated R37 was not cognitive enough to recall how the bruise happened. RN-A stated she believed the bruise was possibly caused from the mechanical lift sling, but could not be sure, and she was going to report the bruise of unknown origin to the director of nursing (DON) so a report can be made to the state agency and an investigation could begin.

During interview on 01/29/15, at 10:19 a.m. the DON stated she was not made aware of the bruising of unknown origin for R37. The DON stated staff are expected to complete incident reports on all bruises of unknown origin, and if the cause is not known staff are expected to immediately contact the administrator, DON, and make the initial report to the state agency, and then begin the investigation.

During interview on 01/29/15, at 10:34 a.m. the administrator confirmed he was not aware of R37's bruise of unknown origin which was discovered on 1/27/15. The administrator stated all staff are expected to immediately report all bruising of unknown origin immediately to the administrator and state agency, and then investigate.

The facility undated Reporting/Investigating Resident Accidents/Incidents policy, directed staff to report all injuries of unknown source to appropriate state agencies promptly, report to the facility administrator, and conduct a thorough

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21990	Continued From page 25 investigation. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures related to immediately reporting to the state agency, the administrator and completing a thorough investigation for vulnerable adult cases. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days.	21990		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement their abuse prohibition policies and procedures for immediate reporting to the facility administrator and state agency (SA) and thorough investigations for 1 of	21995	Acknowledged	2/27/15

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21995	Continued From page 26 1 resident (R37) with a bruise of unknown origin. Findings include: The facility undated Reporting/Investigating Resident Accidents/Incidents policy, directed staff to report all injuries of unknown source to appropriate state agencies promptly, report to the facility administrator, and conduct a thorough investigation. R37's annual Minimum Data Set (MDS) dated 11/6/14, identified R37 had severely cognitive impairment, required extensive staff assistance for all areas of daily living (ADL), and required a mechanical standing lift and assistance of two staff for all transfers R37's care area assessment (CAA) dated 11/12/14, identified R37 had diagnoses including dementia with Lewy bodies and progressing Parkinson's Disease, and R37 was dependent on staff to anticipate needs and rarely/never made decisions regarding daily tasks of life. Review of R37 Progress Notes dated 1/27/15, indicated R37 had large bruises under left breast, left shoulder, and hand. During interview on 1/29/15, at 9:48 a.m. nursing assistant (NA)-B stated the only bruise she was aware that R37 had was a bruise on her left hand which was not new, and NA-B thought it came from the resident bumping the table. NA-B not aware of any other bruising R37 had, however, if she noted bruising she would report it to the nurse immediately. During interview on 1/29/15, at 9:53 a.m. licensed practical nurse (LPN)-A was not aware of any	21995		

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21995	Continued From page 27	21995		

bruising R37 had, but stated she would look at the Progress Notes. After consulting R37's medical record, LPN-A stated it appeared there was a bruise under R37's breast. LPN-A was not aware of the cause, and although she had not seen the bruise, she stated it could possibly have come from the mechanical lift sling. LPN-A confirmed R37's bruise was discovered on 1/27/15, according to the Progress Notes.

During interview on 1/29/15, at 9:56 a.m. registered nurse (RN)-A stated on 1/27/15, staff had reported R 37 had a large bruise under her left breast. RN-A stated no one was aware of how the bruise happened, there was no physical assessment including measuring of the bruise, no report of the bruise of unknown origin had been made to the state agency and/or administrator, and no investigation had been started. RN-A stated when a resident had a bruise/ injury of unknown origin, staff is instructed to ask the resident how it happened, assess the injury, and if the cause of the bruise or injury was unknown, a report would be filed with the state agency. RN-A stated she had talked to aides regarding R37's bruising and she felt it was due to the mechanical lift sling, however, RN-A stated she did not observe the bruising, nor did she document any investigation or interviews.

During interview on 1/29/15, at 10:07 a.m. NA-C stated she gave R37 a bath on 1/27/15, and noticed the large bruise under the residents left breast and reported it to the nurse.

During observation on 1/29/15, at 10:08 a.m. NA-C and LPN-A transferred R37 from the recliner to the wheelchair with the mechanical standing lift. RN-A was in the room to assess R37's bruising. RN-A used a paper measuring

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21995	Continued From page 28 device to measure a dark, purple bruise on R37's lateral left breast, which measured 6 cm (centimeters) x 7 cm. RN-A stated the smaller bruising on R37's hand and lower arms were older bruises and she believed they came from R37 bumping the table. RN-A stated R37 was not cognitive enough to recall how the bruise happened. RN-A stated she believed the bruise was possibly caused from the mechanical lift sling, but could not be sure, and she was going to report the bruise of unknown origin to the director of nursing (DON) so a report can be made to the state agency and an investigation could begin. During interview on 01/29/15, at 10:19 a.m. the DON stated she was not made aware of the bruising of unknown origin for R37. The DON stated staff are expected to complete incident reports on all bruises of unknown origin, and if the cause is not known staff are expected to immediately contact the administrator, DON, and make the initial report to the state agency, and then begin the investigation. During interview on 01/29/15, at 10:34 a.m. the administrator confirmed he was not aware of R37's bruise of unknown origin which was discovered on 1/27/15. The administrator stated all staff are expected to immediately report all bruising of unknown origin immediately to the administrator and state agency, and then investigate. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures related to implementing the facility vulnerable adult policy. The quality assessment and assurance committee could perform random audits to ensure compliance.	21995		

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21995	Continued From page 29 TIME PERIOD FOR CORRECTION: Twenty (21) days.	21995		
22155	MN Rule 4658.4105 Subp. 2 Bedroom Design; New Construction Subp. 2. Usable floor area. The usable floor area and the arrangement and shape of the bedroom must provide space for furnishings, for the free movement of residents with physical handicaps, and for nursing procedures. "Usable floor area" does not include spaces occupied by toilet rooms, vestibules, permanently installed wardrobes, lockers, closets, or heating units. The usable floor area per bed must be at least 100 square feet per resident in double bedrooms, and at least 120 square feet in single bedrooms. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure the single resident rooms on the A-wing of the facility had at least 100 square feet of useable floor space for 13 of 15 rooms. This affected 12 of 12 residents (R54, R70, R39, R32, R15, R41, R67, R14, R59, R33, R3, R61) who resided in the rooms. Findings include: During tour of the A-wing on 1/28/15, at 1:30 p.m. the resident rooms 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35 and 36 were observed to not have at least 100 square feet of useable floor space. On 1/28/15, at 1:37 p.m. R54 reported there was	22155	Acknowledged	2/27/15

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22155	Continued From page 30 plenty of space to get around in the room with the walker, and had no concerns with the size of the room. On 1/28/15, at 1:40 p.m. R15 stated there could be more space in her room and reported it is hard moving around in the room with the wheelchair, however, she did not want to switch rooms and had not contacted anyone in the facility regarding switching rooms. On 1/28/15, at 1:43 p.m. R39 stated she had no issues with the room size and was able to move around with no difficulty. On 1/28/15, at 1:45 p.m. R32 stated he was completely satisfied with his room, had no complaints. On 1/28/15, at 1:55 p.m. R70 stated she had no difficulties getting around her room and was satisfied. All rooms were noted to all be clean, orderly, and decorated . When interviewed on 1/28/15, at 2:00 p.m. the housekeeping services employee stated the rooms on the A-wing were smaller, but was still able to clean the space adequately with no problems. When interviewed on 1/28/15, at 2:15 p.m. nursing assistant (NA)-A stated the rooms are smaller on the A-wing, however, there were no difficulties taking care of residents due to the room sizes, even when mechanical lifts are utilized. During interview on 1/28/15, at 2:35 p.m. the	22155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00477	A. BUILDING: _____ B. WING _____	01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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22155	Continued From page 31 facility environmental services director (ESD) stated the single rooms on the A-wing were less than the required 100 square feet of useable floor space, and the faciltiy would be applying for a room wavier. When interviewed on 1/29/15, at 9:05 a.m. the administrator confirmed the rooms on the A-wing continue to have less than 100 square feet of usable space and would be applying for the waiver again. SUGGESTED METHOD FOR CORRECTION: The administrator could apply for the federal waiver and monitor identified rooms on an ongoing basis for safety and resident satisfaction. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days.	22155		