#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: K6L0

### ${\bf MEDICARE/MEDICAID\ CERTIFICATION\ AND\ TRANSMITTAL}$

	PART	I - TO BE COM	PLETED BY T	THE STAT	E SURVEY AGENCY	Facility ID: 00477		
MEDICARE/MEDICAID PROVIDER N     (L1) 245537	NO.	3. NAME AND AD (L3) MINNEWAS			H SERVICES	4. TYPE OF ACTION: 7(L8)  1. Initial 2. Recertification		
$2. STATE\ VENDOR\ OR\ MEDICAID\ NO.$		(L4) 605 MAIN S	TREET, PO BO	X 40		3. Termination 4. CHOW		
(L2) <b>328542100</b>		(L5) STARBUCK	, MN		(L6) <b>56381</b>	5. Validation 6. Complaint		
5. EFFECTIVE DATE CHANGE OF OW	NERSHIP	7. PROVIDER/SUI	PPLIER CATEGOR	Y	<u>02</u> (L7)	7. On-Site Visit 9. Other		
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint		
6. DATE OF SURVEY 03/19	<b>0/2015</b> (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF			
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING DATE: (L35)		
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31		
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS:					
From (a):		X A. In Compliar			And/Or Approved Waivers Of The	e Following Requirements:		
To (b):		Program Re			2. Technical Personnel	6. Scope of Services Limit		
10 (b).		Compliance	e Based On:		3. 24 Hour RN	7. Medical Director		
12.Total Facility Beds	<b>65</b> (L18)	1. A	Acceptable POC		4. 7-Day RN (Rural SNF)			
		D. N. C.	t M.B.		5. Life Safety Code	9. Beds/Room		
13.Total Certified Beds	<b>65</b> (L17)		pliance with Program ents and/or Applied		* Code: <b>A, 8</b>	(L12)		
14. LTC CERTIFIED BED BREAKDOWN	Ī				15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
65					()()			
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARK								
	X3 (II AI I LICABLE S	HOW LIC CANCELL	LATION DATE).					
See Attached Remarks								
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY AP	PROVAL Date:		
Tammy Williams, H	FE NEII		03/26/2015	(L19)	Mark Meath	, Enforcement Specialist 03/26/2015 (L20)		
	PART II - TO	BE COMPLETE	D BY HCFA R	EGIONAI	OFFICE OR SINGLE STAT			
19. DETERMINATION OF ELIGIBILITY	Y		IPLIANCE WITH C	CIVIL	21. 1. Statement of Finance			
_X 1. Facility is Eligible to Par	rticipate	RIGI	HTS ACT:		<ol> <li>Ownership/Control</li> <li>Both of the Above :</li> </ol>	Interest Disclosure Stmt (HCFA-1513)		
2. Facility is not Eligible								
	(L21)							
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	24. LTC AGREEMI	ENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION	BEGINNING	DATE	ENDING DAT	E	VOLUNTARY 00	INVOLUNTARY		
07/27/1989					01-Merger, Closure	05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburseme	nt 06-Fail to Meet Agreement		
25. LTC EXTENSION DATE:	27. ALTERNATIV	E SANCTIONS			03-Risk of Involuntary Termination	OTHER		
	A. Suspension	of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change		
			(L44)			00-Active		
(L27)	B. Rescind Sus	pension Date:						
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/C	CARRIER NO.		30. REMARKS			
		03001						
	(L28)	-		(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (	OF APPROVAL DA	TE				
	(L32)	03/23/2015		(L33)	DETERMINIATION APPRO	A/A I		
	(L32)			(1.33)	DETERMINATION APPRO	VAL		

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00477

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

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.

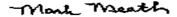
Your request for waiver of F458 has forwarded to CMS and recommended for approval based on the submitted documentation.

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, 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



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.

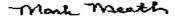
On March 19, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 29, 2015. We presumed, based on your 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, 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

### Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

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

(Y1) Provider / Supplier / CLIA / Identification Number 245537	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 3/19/2015			
Name of Facility		Street Address, City, State, Zip Code				
MINNEWASKA COMMUNITY HEALTH SERVICES		605 MAIN STREET, PO BOX 40				

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	Correction Completed 02/27/2015	ı	F0226		Correction Completed 02/27/2015		ID Prefix	F0241		Correction Completed 02/27/2015
Reg. # LSC	483.13(c)(1)(i	i)-(iii), (c)(2) -	Reg. # LSC	483.13(c)				Reg. # LSC	483.15(a)		_
ID Prefix Reg. # LSC	483.20(k)(3)(i	Correction Completec 02/27/2015	I ID Prefix	483.25(h)		Correction Completed 02/27/2015			F0329 483.25(I)		Correction Completed 02/27/2015
ID Prefix Reg. # LSC	F0428 483.60(c)	Correction Completed 02/27/2015	I ID Prefix	F0431 483.60(b), (d), (e)	)	Correction Completed 02/27/2015		Reg. #			
ID Prefix Reg. # LSC			I ID Prefix Reg. # LSC					ID Prefix Reg. # LSC			
ID Prefix Reg. # LSC			ı								
Reviewed B	3v	Reviewed By	Date:	Signature	of Sur	vevor:				Date:	
State Agen		JS/mm	03/26/20	_		603					26/2015
	-	Reviewed By	Date:	Signature						Date:	
Followup t	o Survey Con 1/29/	•		Check for any Uncorrected					Summary o		NO



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 00477	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 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) D	ate
ID Prefix	20302	(	Correction Completed 02/27/2015	ID Prefix	20565	Correction Completed 02/27/2015	t	ID Prefix	21426		Correction Completed 02/27/2015
	MN State Stat			Reg. # LSC	MN Rule 4658.040				MN St. State		
	21530 MN Rule 4658	0 3.1310 A.B.			21535 MN Rule4658.131		Ŀ	- 3	21620 MN Rule 46		Correction Completed 02/27/2015
ID Prefix Reg. # LSC	21805 MN St. Statut	0	Correction Completed 12/27/2015 Gul	ID Prefix Reg. # LSC	21990 MN St. Statute 620	Correction Completec 02/27/2015	t		21995 MN St. State		
ID Prefix Reg. # LSC	22155 MN Rule 4658	0 3.4105 Subj	Correction Completed 12/27/2015	Reg. #			t	ID Prefix Reg. # LSC			
ID Prefix Reg. # LSC			Correction Completed	ID Prefix Reg. # LSC				ID Prefix Reg. # LSC			
Reviewed E	,	Reviewed I JS/mm	Зу	Date: 03/26/20	- 3	of Surveyor: 32603				Date: 03/	26/2015
Reviewed E	Ву	Reviewed I	Зу	Date:	Signature o	of Surveyor:				Date:	
	o Survey Com 1/29/2 M: REVISIT RI	2015				Uncorrected De Deficiencies (C					NO

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: K6L0

020499

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART	I - TO BE COM	PLETED BY T	THE STAT	E SURVEY AC	GENCY	I	acility ID: 00477
MEDICARE/MEDICAID PROVIDER N     (L1) 245537  2.STATE VENDOR OR MEDICAID NO.	О.	3. NAME AND AD (L3) MINNEWAS (L4) 605 MAIN S'	SKA COMMUNI	TY HEALT	H SERVICES		4. TYPE OF ACTION:	2 (L8) 2. Recertification
(L2) 328542100		(L5) STARBUCK		21.10	(L6)	56381	3. Termination 5. Validation	4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OW (L9)	NERSHIP	7. PROVIDER/SUI	PPLIER CATEGOR	RY 09 ESRD	<u>02</u> (L7	) 22 CLIA	7. On-Site Visit  8. Full Survey After Co	9. Other mplaint
6. DATE OF SURVEY 01/29 8. ACCREDITATION STATUS:  0 Unaccredited 1 TJC 2 AOA 3 Other	/ <b>2015</b> (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING	DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b):  12. Total Facility Beds  13. Total Certified Beds  14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 65 (L37) (L38)  16. STATE SURVEY AGENCY REMARK	65 (L18) 65 (L17) 19 SNF (L39) SS (IF APPLICABLE S	Compliance1. A  X B. Not in Com Requirem  ICF  (L42)	nce With equirements e Based On: Acceptable POC appliance with Programents and/or Applied  IID  (L43)	m	2. Tecl 3. 24 I 4. 7-D	hnical Personnel Hour RN ay RN (Rural SNF) Safety Code B, 8	e Following Requirements:  6. Scope of Servi 7. Medical Direc 8. Patient Room s 9. Beds/Room  (L12)  (L15)	tor
17. SURVEYOR SIGNATURE  Christina Martinson	HFE NEII	Date :	02/21/2015	g 100		VEY AGENCY AP	, Enforcement Specia	
	PART II - TO	BE COMPLETE	D BY HCFA R	(L19) EGIONAL	OFFICE OR	SINGLE STAT	E AGENCY	(L20)
DETERMINATION OF ELIGIBILITY			MPLIANCE WITH O	CIVIL	2.		ial Solvency (HCFA-2572) interest Disclosure Stmt (HCFA	A-1513)
22. ORIGINAL DATE  OF PARTICIPATION  07/27/1989  (L24)	23. LTC AGREEMI BEGINNING (L41)		24. LTC AGREEM ENDING DAT		26. TERMINA VOLUNTARY 01-Merger, Close 02-Dissatisfactio	_00	INVOLUNT 05-Fail to M	L30)  CARY eet Health/Safety eet Agreement
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVE A. Suspension of B. Rescind Sus	of Admissions:	(L44)		03-Risk of Involu 04-Other Reason	ntary Termination for Withdrawal	OTHER 07-Provider 00-Active	Status Change
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/C	CARRIER NO.		30. REMARKS			
	(L28)	03001		(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (	OF APPROVAL DA	ATE				
	(L32)			(L33)	DETERMINA	ATION APPRO	VAL	

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00477

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

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.



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:

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

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

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

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

### <u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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

#### **DEPARTMENT CONTACT**

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

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

Minnewaska Community Health Services February 13, 2015 Page 4

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.

Minnewaska Community Health Services February 13, 2015 Page 5

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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 Weath

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245537	B. WING		· · · · · · · · · · · · · · · · · · ·	01/	29/2015	
	PROVIDER OR SUPPLIER	HEALTH SERVICES		605	EET ADDRESS, CITY, STATE, ZIP CODE MAIN STREET, PO BOX 40 RBUCK, MN 56381			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMEN		FC	000				
F 225 SS=D	signature is not rec page of the CMS-2	, (c)(2) - (4) PORT	F2	225			2/27/15	
	been found guilty of mistreating resider had a finding enter registry concerning of residents or mis and report any kno court of law agains indicate unfitness f	ot employ individuals who have of abusing, neglecting, or also by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a tran employee, which would or service as a nurse aide or to the State nurse aide registry ities.						
	involving mistreatm including injuries of misappropriation of immediately to the to other officials in through established	nsure that all alleged violations nent, neglect, or abuse, f unknown source and f resident property are reported administrator of the facility and accordance with State law d procedures (including to the ertification agency).						
	violations are thoro	ave evidence that all alleged bughly investigated, and must ential abuse while the progress.						
ABORATOR	to the administrato	ivestigations must be reported r or his designated  DER/SUPPLIER REPRESENTATIVE'S SIGN	IATUDE		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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	PROVIDER OR SUPPLIER	HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CO 605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381	<b>.</b>		
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F 225	with State law (incl certification agency incident, and if the appropriate correct	age 1 to other officials in accordance uding to the State survey and y) within 5 working days of the alleged violation is verified tive action must be taken.  NT is not met as evidenced	F 2	25			
	review, the facility the administrator a complete a thoroug resident (R37) with Findings include:  R37's annual Minir 11/6/14, identified impairment, requir for all areas of dail mechanical standing staff for all transfer.  R37's care area as 11/12/14, identified dementia with Lew Parkinson's Diseas staff to anticipate redecisions regarding.  Review of R37 Proindicated R37 had left shoulder, and houring interview or During interview or staff to anticipate or indicated R37 had left shoulder, and houring interview or staff to anticipate or indicated R37 had left shoulder, and houring interview or staff to anticipate or indicated R37 had left shoulder, and houring interview or staff to anticipate or indicated R37 had left shoulder, and houring interview or staff to anticipate or indicated R37 had left shoulder, and houring interview or staff to anticipate or indicated R37 had left shoulder, and houring interview or staff to anticipate or indicated R37 had left shoulder, and houring interview or staff to anticipate or indicated R37 had left shoulder.	ssessment (CAA) dated R37 had diagnoses including y bodies and progressing se, and R37 was dependent on seeds and rarely/never made g daily tasks of life.  gress Notes dated 1/27/15, large bruises under left breast, hand.		It is the policy of Minnewask Home to complete backgrou checks and criminal conviction investigation checks on all in making application for employing this facility. It is also the polifacility to investigate all unex injuries, including bruises, altinjuries of unknown source. states that "the administrator designee shall be notified im any resident sustaining an in unexplained injury or harm." of Nursing Services or her deconduct an investigation and information into the resident' record. Per facility policy, im reporting to the OHFC must when an allegation of mistreabuse is alleged. The facility reviewed and stands as writt In the instance of resident Rawas filed with OHFC on 1/30 received notice on 2/03/2015 will be no further investigation investigation, it was determined to the original properties.	nd screening on ndividuals byment with cy of the plained brasions, and The policy or his mediately of jury, The Director esignee will I record this s clinical amediate be done atment or y policy was en.  37, a report 0/2015 and 5 that there in. Per facility ned that the ner fastened		
	assistant (NA)-B st	ated the only bruise she was d was a bruise on her left hand		or slipped up on top of her be a transfer causing bruising to	reasts during		

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	PROVIDER OR SUPPLIER	HEALTH SERVICES		60	TREET ADDRESS, CITY, STATE, ZIP CODE 05 MAIN STREET, PO BOX 40 TARBUCK, MN 56381		
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F 225	which was not new from the resident b aware of any other she noted bruising nurse immediately.  During interview on practical nurse (LP bruising R37 had, be the Progress Notes medical record, LP was a bruise under aware of the cause seen the bruise, she come from the mediconfirmed R37's bruizing interview on registered nurse (Phad reported R 37 left breast. RN-As how the bruise hap assessment including report of the bruise made to the state a and no investigation stated when a residunknown origin, staresident how it hap if the cause of the bar a report would be find RN-A stated she had R37's bruising and mechanical lift sling did not observe the document any investigations.	, and NA-B thought it came umping the table. NA-B not bruising R37 had, however, if she would report it to the	F 2	225	breast. The belt needs to be faster under her breasts to be used appropriately. Staff were educated immediately and education provide about proper transfer technique at Staff In-service on 2/17/15. Staff in in not reporting the bruises were edon the facility policy and the need to immediately to the Administrator, th DON, and OHFC when the origin is unknown. Education regarding immereporting was also presented at the Staff In-service on 2/17/15. The DON or her designee will evaluate residents utilizing the PAL lift for trained will be determined if staff are unappropriately. The DON will monitor any incident reports with the interdisciplinary team and audit report one quarter and submit these first for review and recommendations to Quality Assurance Committee at the 2015 meeting, to ensure that all repare being filed immediately and tim Staff education will be presented to 02/17/15 and F/U with those who dattend by 2/27/15.  Date corrected: February 27, 2015	d an All avolved ducated or report de se all auste all ansfers sing it or daily corts andings of the e June, ports ely. In id not	

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		245537	B. WING			01/	29/2015	
	PROVIDER OR SUPPLIER	HEALTH SERVICES		60	REET ADDRESS, CITY, STATE, ZIP CODE 5 MAIN STREET, PO BOX 40 FARBUCK, MN 56381	<u> </u>		
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F 225	stated she gave R3 noticed the large brobreast and reported breast and reported During observation NA-C and LPN-A trecliner to the whee standing lift. RN-A R37's bruising. RN device to measure lateral left breast, w (centimeters) x 7 crobruising on R37's holder bruises and s R37 bumping the transpened. RN-A s was possibly cause sling, but could not report the bruise of of nursing (DON) s state agency and a During interview on DON stated she was bruising of unknow stated staff are expreports on all bruise cause is not known immediately contact make the initial report the inverse During interview on administrator confirence of the reports of the inverse of the large process	To a bath on 1/27/15, and ruise under the residents left of it to the nurse.  on 1/29/15, at 10:08 a.m. ansferred R37 from the elchair with the mechanical was in the room to assess I-A used a paper measuring a dark, purple bruise on R37's which measured 6 cm m. RN-A stated the smaller rand and lower arms were the believed they came from able. RN-A stated R37 was ghoto recall how the bruise at from the mechanical lift be sure, and she was going to unknown origin to the director of a report can be made to the in investigation could begin.  101/29/15, at 10:19 a.m. the as not made aware of the in origin for R37. The DON rected to complete incident est of unknown origin, and if the instaff are expected to the administrator, DON, and out to the state agency, and	F 2	225				

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	PROVIDER OR SUPPLIER  ASKA COMMUNITY H	IEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381	•	
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F 225 F 226 SS=D	investigate.  The facility undated Resident Accidents to report all injuries appropriate state agracility administrato investigation.  483.13(c) DEVELO ABUSE/NEGLECT  The facility must depolicies and proced mistreatment, negle	Reporting/Investigating /Incidents policy, directed staff of unknown source to gencies promptly, report to the r, and conduct a thorough  P/IMPLMENT ETC POLICIES  velop and implement written	F 22			2/27/15
	by: Based on observatoreview, the facility for prohibition policies reporting to the facility for agency (SA) and the second for a resident (R37) with the facility undated. The facility undated Resident Accidents to report all injuries appropriate state age facility administration investigation.	ion, interview, and document ailed to implement their abuse and procedures for immediate lity administrator and state orough investigations for 1 of the a bruise of unknown origin.  Reporting/Investigating /Incidents policy, directed staff of unknown source to gencies promptly, report to the r, and conduct a thorough		It is the policy of Minnewaska Luth Home to follow the policy and proof for immediately reporting issues of Vulnerable Adult. The policy states immediate reporting shall take placan allegation of mistreatment or at alleged. Injuries of unknown origing include bruises, abrasions, and ar injury. Education was provided to 02/17/2015, to immediately notify the administrator and DON if an alleged violation have occurred to ensure reporting is done according to the requirements.  In the instance of resident R37, and has been filled with OHFC on 1/30/2 results of the investigation submitter.	s that ce when buse is ny other staff on he ed MDH	

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F 226	11/6/14, identified Fimpairment, require for all areas of daily mechanical standin staff for all transfers.  R37's care area as 11/12/14, identified dementia with Lewy Parkinson's Diseas staff to anticipate nudecisions regarding.  Review of R37 Propindicated R37 had left shoulder, and human left	R37 had severely cognitive ed extensive staff assistance of living (ADL), and required a glift and assistance of two sessment (CAA) dated R37 had diagnoses including of bodies and progressing e, and R37 was dependent on eeds and rarely/never made gradily tasks of life.	F 2	2/2/15. further Staff in educated administration was ed In-servissues to followin all M access The Ohon all C submitted To ensuation to ensuation a timely daily arrinterdistration quarter review Quality 2015 m presentations of those was a timely daily arrinterdistration of the presentation of the presenta	Received word on 2/3/15 action is necessary at this evolved in not reporting haved to investigate; report to strator, DON, and OHFC inversity, and document incident ducated on 2/17/15 at an Alvice R/T reporting vulnerable immediately as well as the weak has been laminated and IARs with-in the facility for each to the procedure for report HFC desktop icon has been computers in the facility for ting a report.  The polymer in the polymer in the sciplinary team daily for one of and submit these findings and recommendations to the polymer in the sciplinary team daily for one of and submit these findings and recommendations to the polymer in the facility for one of the polymer in the sciplinary team daily for one of the polymer in the sciplinary team daily for one of the polymer in the sciplinary team daily for one of the polymer in the sciplinary team daily for one of the polymer in the sciplinary team daily for one of the polymer in the sciplinary team daily for one of the polymer in t	time. e been the f origin is . Staff l Staff e adult process placed easy ting. n placed ease in g filed in nitor e for he he June as vith		

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	PROVIDER OR SUPPLIER	HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP 605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381			
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F 226	registered nurse (had reported R 37 left breast. RN-A how the bruise had assessment include report of the bruise made to the state and no investigation stated when a resunknown origin, stresident how it had if the cause of the a report would be RN-A stated she had report would be RN-A stated she had report would be RN-Batted she had report would be RN-A stated she had reported bruing interview of stated she gave R noticed the large be breast and reported breast and reported bruing observation NA-C and LPN-A recliner to the who standing lift. RN-A recliner to the who standing lift.	RN)-A stated on 1/27/15, staff had a large bruise under her stated no one was aware of opened, there was no physical ding measuring of the bruise, no e of unknown origin had been agency and/or administrator, on had been started. RN-A ident had a bruise/ injury of aff is instructed to ask the opened, assess the injury, and bruise or injury was unknown, filed with the state agency. It is added to aides regarding a she felt it was due to the epsetigation or interviews.  In 1/29/15, at 10:07 a.m. NA-C 37 a bath on 1/27/15, and or or one was aware of the state agents and the residents left.	F 2	226			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 226 F 241 SS=D	of nursing (DON) sistate agency and a During interview on DON stated she was bruising of unknown stated staff are expreports on all bruise cause is not known immediately contact make the initial reported then begin the investigate of unknown administrator confirems and in the staff are expected bruising of unknown administrator and sinvestigate.  483.15(a) DIGNITY INDIVIDUALITY  The facility must promanner and in an elembance each result recognition of horizontal training facility is assed on observator review the facility facil	unknown origin to the director of a report can be made to the in investigation could begin.  01/29/15, at 10:19 a.m. the is not made aware of the in origin for R37. The DON ected to complete incident es of unknown origin, and if the staff are expected to it the administrator, DON, and out to the state agency, and stigation.  01/29/15, at 10:34 a.m. the imed he was not aware of inown origin which was in it was in	F 226		rith , that	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245537	B. WING		01/2	29/2015	
	PROVIDER OR SUPPLIER	HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381	1		
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F 241	Findings include:  R2's current care p R2 had diagnoses extremities, brain ir careplan identified impairment, require complete all activiti including requiring related to hemiparis indicated he prefers for all meals.  During observation was sitting in his what a tan brown food substant R2's face, while the to run down his chi upper chest area o which consisted of toast, and the tan be been dripping down have food on his fat to the dining room  During observation was done eating his sweet and sour por and strawberry sau dining room by ped right foot, and using wheelchair out of the assistant (NA)-E ca assisted R2 to the activities director (A	lan dated 12/16/14, identified of hemiplegia affecting his left njury, and epilepsy. The R2 had moderate cognitive ed assistance from staff to es of daily living (ADL), extensive assistance grooming sis of his left side, and so to wear a clothing protector.  On 1/27/15, at 11:12 a.m. R2 heelchair watching t.v. R2 had abstance on the right side of om the corner of his mouth, all om of his chin. Some of the tank once was dry and crusted onto the tank food substance continued in area onto his shirt. The right of R2's shirt had food on it some cheerios, crumbs of the some cheerios, crumbs of the corner food substance that had in his chin. R2 continued to ce and clothing until he went	F 241	maintains and enhances each residignity and respect in full recognition their individuality. The Director of or her designee is responsible to that all residents are cared for in a manner and environment that enheach resident's dignity. In the instance of resident R2, he medical history of traumatic brain many years ago resulting in (Lt.) shemi-paresis. As a result, he poof food in his cheek which then runs his face and clothing after he leave table. He has now been Care Place have oral cares after all meals. So also to check face and shirt after the ensure that they are clean. Staff if the been notified during shift change are education was provided on dignity All Staff In-service on 2/17/15. To ensure compliance, daily audits conducted for one week beginning 2/5/2015, then bi-weekly for 1 more until 100% compliance is reached Audits will be completed by the Dodesignee. Results of audits will be to the Quality Assurance Committed June 2015 meeting for review and recommendation.  Date corrected 02/27/2015	on of Nursing ensure a ances has a injury ided kets out onto es the nned to taff are meals to nave and at the s will be on the or a brought ee at the		

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F 241	had a red, moist su side of his face from to his mustache, and the side of his face from use the bed pan and call light and the aid p.m. R2 continued his face.  At 1:23 p.m. NA-E at to assist the residents room have the a red, moist he left side of his famouth to his mid character area.  At 3:05 p.m. R2 was sitting in the fireside the red moist substiting in the fireside the red moist substituted R2 always him eals, and his shirt at times. NA-E state R2's face and cloth "No, I do not feel the and clothing] is digrid During interview on registered nurse (R stuck in his mustace).	to watch t.v. in his room and bstance running down the left in the corner of his mouth, up and down his mid chin area.  28/15, NA-E and NA-F and assisted R2 to his bed to id urinal. R2 was provided his des left the room at 12:47 to have the red substance on and NA-F entered R2's room and off the bedpan. After ericare, NA-E and NA-F left at 1:30 p.m. R2 continued to ist substance running down ace from the corner of his nin area and along his  s in his wheelchair and was a room. R2 continued to have ance running down the left in the corner of his mouth to long his mustache area.  1/29/15, at 10:36 a.m. NA-E as food on his face after talso gets dirty during meals and stated, at this [having food on his face	F 2	41			

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F 241	was not dignified fo on his face or clothed on his face or clothed During interview on of nursing (DON) states food on his face and expect staff to wipe water, change his contained or cares. The DO the residents dignity and clothing.  Review of facility por 2/2014, directed states family and visitor's, kindness, respect at 483.20(k)(3)(ii) SEF PERSONS/PER CATTHE SERVICES provious to be provided by accordance with eacare.  This REQUIREMENT by:  Based on observative review, the facility face.	ing his face, and also stated it it it the resident to have food left es after dining.  1/29/15, at 11:01 a.m. director stated she has seen R2 with display contained she has seen R2 with display contained she has seen R2 with display contained she would his face, give him a drink of slothes if needed, and provide N agreed it is not promoting to leave food on his mouth of slothes if needed, and provide N agreed it is not promoting to leave food on his mouth of slothes if needed, and provide N agreed it is not promoting to leave food on his mouth of slothes and fellow workers with and dignity.  RVICES BY QUALIFIED ARE PLAN led or arranged by the facility y qualified persons in inch resident's written plan of the solution, interview, and document ailed to follow the written care interventions for 1 of 4	F 24	It is the policy of Minnewaska Luth Home that "a comprehensive care that includes measurable objective timetables to meet the resident's m	plan s and edical,	
	1/13/15, identified F	imum Data Set (MDS) dated R58 had severe cognitive ed total staff assistance for all		nursing, mental and psychological shall be developed for each resider is being followed by a qualified personal The care plan for R58 has been reand stands as written to utilize the chair with the seat belt at all times of	nt" and son. viewed ower	

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(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 282	areas of daily living fall in the facility.  R58's care plan data risk of falls and retransfers and mobil staff to reduce the to ensure resident with seatbelt at all the meals. The care pland the resident back in seatbelt after R58 v.  During observation was not transferred the seat belt after bein the tall wheel charmonitoring R58 in the tall wheel chair without be used for meal timestaff had walked by resident was not in safety belt attached used for fall preven propelled R85 to he During interview on verified the tall whe seated in unsupervand was only to be and in direct supervalues.	ted 1/21/15, identified R58 had equired assistance with lity. The care plan instructed risk of serious injury from falls was using the low wheel chair imes while up, except when at lan instructed staff to transfer nto the low wheelchair with the was done eating.  on 1/29/15, at 8:15 a.m. R58 It to the low wheel chair with breakfast, and was brought out air without a seat belt to sit in lary. No staff had been he tall wheel chair which was he seat belt. During ation, R58 remained in the tall as a seat belt which was only to me. Although several nursing a R58, staff did not identify the the low wheelchair with the das had been assessed to be ation. At 8:58 a.m. NA-C er room.  11/29/15, at 9:05 a.m. NA-H eel chair which R58 had been ised did not have a seat belt, used when R58 was eating	F 2		then at mealtime. At mealtime, she placed in the tall chair without the seatbelt.  All staff have been educated on the to follow all residents' plan of care All Staff In-service held on 02/17/2 One observational audit will be condaily for one week, then bi-weekly week and then one time a month formonth by the DON or her designed ensure the Care Plan is being follostaff.  Results of audits will be brought to Quality Assurance Committee at the 2015 meeting for review and recommendation.  Date corrected: 02/27/2015	e need at an 015. mpleted for one or one e to owed by	

-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245537	B. WING _		01/:	29/2015
	PROVIDER OR SUPPLIER  ASKA COMMUNITY F	HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 282	resident.  During interview on registered nurse (Runsupervised in the equipped with the sof time, and stated, absolutely would nowheel chair without R58's care plan insiresident was in the seatbelt on at all time.  During interview on stated R58 utilized twas higher and use was lower to the ground NA-I stated R58 was leaned forward in head the resident was can wheelchair with the director of nursing (assessed to have the chair and a seat befalling forward out of would expect staff to the The facility policy tit Plans-Comprehens The comprehensive to Enhance the opti	1/29/2015, at 11:12 a.m. N)-A verified R58 had been wheel chair which was not eat belt for extended periods "On a normal day, [R58] ot," be unsupervised in the tall the seatbelt. RN-A stated tructed staff to ensure the low wheelchair with the nes, except when eating.  1/28/2015, at 1:00 p.m. NA-I two different wheel chairs; one of for meals, and the other bund and had a seat belt on it. is a fall risk because she er wheelchair, which is why re planned to be in a low seat belt.  1/29/2015, at 2:49 p.m. the DON) stated R58 was ne low to the ground wheel lit to prevent the resident from of her wheelchair, and she o follow R58's care planned.	F 28	32		
F 323 SS=D	HAZARDS/SUPER		F 32	23		2/27/15

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245537	B. WING		01/2	29/2015
	PROVIDER OR SUPPLIER	HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 323	environment remai as is possible; and adequate supervisi prevent accidents.	ns as free of accident hazards each resident receives on and assistance devices to	F 323			
	by: Based on observareview the facility fainterventions as as (R58) reviewed for Findings include: R58's quarterly Mir 1/13/15, identified limpairment, require areas of daily living fall in the facility. R58's care plan da a risk of falls and retransfers and mobistaff to reduce the to ensure resident with seatbelt at all meals. The care p the resident back in seatbelt after R58 v. R58's Nursing Progindicated R58 had 12/25/14, however There was no furth	nimum Data Set (MDS) dated R58 had severe cognitive ed total staff assistance for all (ADL), and had sustained a ted 1/21/15, identified R58 had equired assistance with lity. The care plan instructed risk of serious injury from falls was using the low wheel chair times while up, except when at lan instructed staff to transfer nto the low wheelchair with the		It is the policy of Minnewaska Luth Home that "early fall and injury risk assessment and data gathering by licensed personnel shall help to es appropriate and timely safety interventions, which will ensure thand well-being of the residents." It intent of the facility to ensure that residents 'environments remain as accident hazards as possible, each receives adequate supervision and assistance devices to prevent acci R58's care plan has been reviewed remains the same.  All staff have been educated on the to follow all residents' plan of care All Staff In-service held on 02/17/2 Emphasis had been placed on follow the care plan to ensure that adequivataff are involved in repositioning residents and that the care is being provided as outlined to ensure the and well being of the resident.  This will be audited weekly for 2 with administrator or his designee with a designee of the administrator or his designee with a designee of the resident.  This will be audited weekly for 2 with administrator or his designee with a designee of the resident.  This will be audited weekly for 2 with a deministrator or his designee of the administrator or his designee or making walking rounds. This will proportunity to observe for a safe environment, resident satisfaction,	tablish e safety is the all s free of dents. d and e need at an 015. bwing ate g safety eeks by while brovide	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245537	B. WING			01/2	29/2015
	PROVIDER OR SUPPLIER  ASKA COMMUNITY H	HEALTH SERVICES		60	TREET ADDRESS, CITY, STATE, ZIP CODE 05 MAIN STREET, PO BOX 40 TARBUCK, MN 56381		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	was re-educated to wheelchair were look completing cares.  R58's assessment dated 1/13/15, indice belt on when in the considered a restrate assessment, the restrate she was in her wheelchair on a dark wheelchair on a string on the tabs alarm to side of R58's swear a.m. nursing assist practical nurse (LP) the dinning area, so R58 until other staff During multiple obs 12:56 p.m. to 2:28 R58 was seated in chair with a tabs alaw wheel chair by Velcalarm box to a clip sweater near her near he	titled Observation Report cated the resident had a safety wheelchair, which was int. According to the sident leaned forward when elchair, and required the all times or would, "Fall out of ity basis."  on 1/28/2015, at 11:45 a.m. in 8 was leaning forward and wheel chair which was slightly elchair had a tabs alarm to of the wheel chair with that went from the alarm box of a clip attached to the right ter near her waist. At 11:47 ant (NA)-J instructed licensed N)-E not to remove R58 from to she could keep an eye on f came back.  Bervations on 1/28/2015, from p.m. and again at 3:19 p.m., the low [to the floor] wheel arm secured to the back of the ro and the string from the attached to the center of R58's eck. R58 had the seat belt lips, and the resident was	F3	23	brought to the Quarterly Quality Assurance Committee at the June meeting for review and recommend Date corrected: 02/27/2015		
		on 1/29/15, at 8:15 a.m. R58 to the low wheel chair with					

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245537	B. WING			01/	29/2015
	PROVIDER OR SUPPLIER	HEALTH SERVICES		60	REET ADDRESS, CITY, STATE, ZIP CODE 5 MAIN STREET, PO BOX 40 TARBUCK, MN 56381	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	the seat belt after be in the tall wheel chair monitoring R58 in the tall wheel chair monitoring R58 in the tequipped with the seated in unsupervand was only to be and in direct supervand was existent was set without the seat belong interview on registered nurse (Runsupervised in the equipped with the soft time, and stated, absolutely would now wheel chair without buring interview on stated R58 utilized was higher and use was lower to the great state of the province of the provinc	reakfast, and was brought out air without a seat belt to sit in ary. No staff had been he tall wheel chair which was ne seat belt. During tion, R58 remained in the tall a seat belt which was only to me. Although several nursing R58, staff did not identify the the low wheelchair with the las had been assessed to be tion. At 8:58 a.m. NA-Cer room.  1/29/15, at 9:05 a.m. NA-Hel chair which R58 had been ised did not have a seat belt, used when R58 was eating vision of staff.  on 1/29/2015, at 11:06 a.m. n front of the bird aviary while ated in the tall wheel chair t, and walked away from the wheel chair which was not eat belt for extended periods "On a normal day, [R58] ot," be unsupervised in the tall	F3	223			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245537	B. WING _		01/	29/2015
	PROVIDER OR SUPPLIER	HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 323	leaned forward in hithe resident is to be seat belt.  During interview on stated R58 had an athe tall wheel chair NA-H stated R58 wheel chair with the done eating.  During interview on LPN-A stated R58 higher and included one for use when eall other times. LPN chair only for meals	ge 16 er wheelchair, which is why e in a low wheelchair with the  1/29/2015, at 9:12 a.m. NA-H alarm in use when seated in but did not have a seat belt. as to be transferred to the low e seat belt as soon as she was  1/29/2015, at 9:33 a.m. had several fall interventions in the use of two wheel chairs; ating, and one to be used at N-A stated R58 utilized the tall and was to be transferred to with the seat belt when she	F 32	23		
F 329 SS=D	director of nursing (assessed to have the chair and a seat be falling forward out of the facility policy tite. The facility policy tite Monitoring Plan date residents who have interventions to limit that put them at fall 483.25(I) DRUG REUNNECESSARY DEACH resident's druunnecessary drugster drug when used in the chair of the chai	led Resident Falls and Injury ed 10/11/10, identified risk factors for falling receive t or eradicate the conditions risk. EGIMEN IS FREE FROM	F 32	9		2/27/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245537	B. WING			01/2	29/2015
	PROVIDER OR SUPPLIER			60	TREET ADDRESS, CITY, STATE, ZIP CODE  D5 MAIN STREET, PO BOX 40  TARBUCK, MN 56381		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	indications for its used verse conseque should be reduced combinations of the Based on a compresident, the facility who have not used given these drugs therapy is necessed as diagnosed and record; and reside drugs receive grade behavioral interversidents.	nonitoring; or without adequate use; or in the presence of nces which indicate the dose or discontinued; or any	F3	329			
	by: Based on observareview, the facility indications for use antidepressant me (R22) reviewed whand antidepressant Findings include: The Annual Minimus 10/22/14, identified impairment and hassessment period	um Data Set (MDS) dated I R22 had no cognitive Id no behaviors during the			It is the policy of the Minnewaska Lutheran home that "when antipsyomedications are administered to a resident, it is our responsibility to enthatthe use of medications must included in the resident's individual treatment plan and is based on the prescribing physician's diagnosis are functional assessment; that documentation in the resident's individual treatment plan includes a description observable and measurable terms of symptoms and behaviors that the medication is to alleviate; and a darcollection method to monitor and	nsure be and the vidual on in of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245537	B. WING		01/2	29/2015	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
MINNEWASKA COMMUNITY HEALTH SERVICES				605 MAIN STREET, PO BOX 40			
IVIIIVINEVV	ASKA COMIMUNITY I	HEALIN SERVICES		STARBUCK, MN 56381			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 329	Continued From pa	age 18	F 32	9			
	antidepressant med 8/23/14, 15 milligra Zyprexa (an antips start date of 12/12/			measure changes in symptor behaviors that are to be allev The DON or her designee is to ensure that there is adequing monitoring of behavioral symwould require the continued to	iated." responsible ate ptoms which		
	documentation of in justifying use for the any behavioral inte required by staff.	edical record lacked dentified target behaviors e Remeron and Zyprexa or rventions which may be		antipsychotic medications. R1's physician's orders were R1 has been medicated with mg daily for the diagnoses o disorder. Per resident's prim physician, he was started on	Remeron 15 f depressive ary care Zyprexa 2.5		
		on 1/28/2015, at 11:55 a.m. top of the covers in bed with and lights off.		mg q HS on 12/12/2014 for b had occurred for at least 10 c swearing at staff for having to know he was leaving the faci	days of let staff		
	R22 was seated in four other male res conversation with t	on 1/28/2015, at 6:31 p.m. the dining room eating with idents. R22 engaged in he other male residents seated ted his meal, and stacked the		off his code alert and being recares. Family had stated that medication for these types of and would like the doctor to k happening to see if he could on them. Refused to let the the Code Alert back on so cu	esistive with the was on behaviors know what is be put back nurses put		
	nursing assistant (I	n 01/29/2015, at 10:26 a.m. NA)-C stated R22 had, viors of refusal to get washed		not being monitored with it. monitoring was initiated on 1/ monitoring for aggression and cares. Also, a weekly nurse's been added for documentation	Behavior /1/2015, d refusal of s note has		
	registered nurse (F had behaviors of re device to alert staff however, R22 no lo bracelet because h without staff knowle record lacked targe of Zyprexa and Rel interventions for sta	n 1/29/2015, at 10:52 a.m. RN)-A stated R22 previously befusing to wear a code alert (a fof a resident leaving), onger required the code alert be didn't try to exit the building edge. RN-A verified R22's bet behaviors justifying the use meron, nor any behavioral aff to try for any behaviors N-A stated R22 did not have a		behaviors and interventions to behaviors and interventions to been tried and were success. Monthly medication review work conducted on all residents remained the Minnewaska Lutheran Home Consultant Pharmacists' to remedication regimen and documentation supports the clinical indication continued use of antipsychotic pharmacy consultant reviews followed up by the Case Man	hat have ful. ill be siding at by eview umentation cation for ic drugs. The		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245537	B. WING		01/	29/2015	
NAME OF PROVIDER OR SUPPLIER  MINNEWASKA COMMUNITY HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 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)  SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		D BE	(X5) COMPLETION DATE			
F 329  F 428 SS=D	proper diagnosis for Remeron.  During interview on director of nursing of protocol of the use included identifying interventions, along the target behaviors any behaviors.  During a phone interventing the facility consulting behaviors, interventions and Zyprotose residents recommended in the facility for psycologically for psycological facility for psycolog	ontinued From page 19 roper diagnosis for the use of Zyprexa or emeron.  uring interview on 1/29/2015, at 1:48 p.m. the rector of nursing (DON) verified the expected rotocol of the use of antipsychotic medication cluded identifying target behaviors and terventions, along with ongoing monitoring of the target behaviors by tracking the episodes of the target behaviors by tracking the episodes of the facility consulting pharmacist stated target the endication should be in place for use of the emeron and Zyprexa, and stated especially for the emeron and Zyprexa, and stated target especially for the emeron and Zyprexa, and stated target especially for the emeron and Zyprexa, and stated target especially for the emeron and Zyprexa, and stated target especially for the emeron and Zyprexa, and stated target especially for the emeron and Zypre				2/27/15	
	the attending physic						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245537	B. WING		01/2	29/2015	
NAME OF PROVIDER OR SUPPLIER  MINNEWASKA COMMUNITY HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381	CITY, STATE, ZIP CODE T, PO BOX 40		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROFIT  DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 428	This REQUIREME by: Based on observareview, the facility of ensure 1 of 3 resid an antipsychotic arhad justification for Findings include: The Annual Minimus 10/22/14, identified impairment and has assessment period Review of R22's cult/2015, identified Fantidepressant me 8/23/14, 15 milligra Zyprexa (an antips start date of 12/12/Review of R22's modocumentation of identified monthly of consulting pharmacist's Medicidentified monthly of consulting pharmacisting	tion, interview, and document consulting pharmacist failed to ents (R22), who were taking and antidepressant medication, use.  Important Market (MDS) dated are also and an every medication orders dated are also	F 428	It is the policy of Minnewaska Luthome that "the consultant pharma shall conduct a chart review of resdrug regimen on a monthly basis find purpose of identifying appropriate utilization and compliance with fed state drug review regulations."  The DON or her designee is responsive to ensure that the pharmacist repoir irregularities to the attending physical the director of nursing and these remust be acted upon.  R22's pharmacy consultant note of 01/05/2015, "recent increase in depressive symptoms-no indication reduce Remeron. Zyprexa restart 12/14-will monitor. Appears to toke Pharmacy Consultant note dated 02/09/2015 indicates "behaviors in redirected appears improved on Zinon-pharmacological interventions appear to be helping. Will plan to potential reduction in near future (June 2015)."  The DON or her designee will reviappropriateness of current medicate regimen of all residents and referencements to the primary physician consultant pharmacist for review. The DON will review recommendations.  Audits will be performed on 10% of recommendations for three monthensure that adequate justification provided if the physician does not with the pharmacist's recommendations with the pharmacist's recommendations.	cist cident's cor the drug leral and consible corts any ician, eports lated on to ed erate." ot easily yyrexa. s address approx. ew the ation any and/or ations of the s to is concur		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245537	B. WING		·····	01/2	29/2015
NAME OF PROVIDER OR SUPPLIER  MINNEWASKA COMMUNITY HEALTH SERVICES				60	TREET ADDRESS, CITY, STATE, ZIP CODE 05 MAIN STREET, PO BOX 40 TARBUCK, MN 56381		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 428	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F 4	128	The results of the audits will be preat the quarterly Quality Assurance Committee at the June 2015 meeting will proceed according to recommendations of the committee Date corrected 02/27/2015	ng and	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		TE SURVEY MPLETED
		245537	B. WING		01	/29/2015
	PROVIDER OR SUPPLIER	HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 428	those residents rec specifically for psyc The undated facility Medication Review	eiving these medications, "Not	F 428	3		
F 431 SS=D	The facility must en a licensed pharmac of records of receip controlled drugs in accurate reconciliat records are in order controlled drugs is reconciled.  Drugs and biological labeled in accordant professional princip appropriate access instructions, and the applicable.  In accordance with facility must store a locked compartmer controls, and perminave access to the The facility must propermanently affixed controlled drugs list Comprehensive Drugs Control Act of 1976	nploy or obtain the services of sist who establishes a system t and disposition of all sufficient detail to enable an ion; and determines that drug and that an account of all maintained and periodically als used in the facility must be acce with currently accepted les, and include the ory and cautionary a expiration date when  State and Federal laws, the ll drugs and biologicals in ints under proper temperature to only authorized personnel to	F 43			2/27/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245537	B. WING		01/29/2015	
	PROVIDER OR SUPPLIER	HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION	
F 431	quantity stored is me be readily detected.  This REQUIREMED by: Based on observa	bution systems in which the ninimal and a missing dose can .  NT is not met as evidenced tion, interview, and, document	F 431	It is the policy of Minnewaska Luthe		
	were dated when o was not expired for being administered dated when opened.  Findings include:  On 01/27/15, at 2:0 the D-wing was obsures (LPN)-A. Thinsulin flex pen for when it was opened pharmacy label with of 10/06/14. LPN expected to date all	ailed to ensure insulin pens pened to ensure medication 1 of 1 resident, R48, who was insulin which had not been d.  9 p.m. the medication cart for served with licensed practical ere was a half full Humalog R48 which had no date on d. The insulin pen had a h a delivery date to the facility A confirmed staff were I insulin pens when they are esidents are not receiving		Home that all multi-dose vials, staff "label the medication vial with the da and time opened, the initials of the popening the vial, and the expiration of the vial, not to exceed 28 days, u recommendations differ from the manufacturer."  The DON or her designee is responto ensure that drugs and biological the facility are labeled in accordance currently accepted professional prinincluding the appropriate accessory cautionary instructions, and the expedate when applicable.  All nursing staff have been educated the policy of initialing and dating all multi-dose bottles and vial once open	ate person date nless usible used in e with uciples, and iration d on	
	insulin which is exp determine when the for R48.  R48's January 2018 Record (MAR) indic Humalog insulin ba blood glucose level undated Humalog i evenings.  During interview on	5, Medication Administration cated R48 was to receive the sed on a sliding scale of his l, and had received the nsulin on all but three  101/27/15, at 2:19 p.m. the (DON) stated her expectation		A review was completed by the Pha Consultants on 02/09/2015 and discussion was had in regards to stainitialing and dating multi-dose vials opened. The Pharmacy Consultant provide education to all nursing staf 03/12/2015 related to medication administration.  Audits will be completed by the DO her designee on all medication carts ensure that proper labeling has occorn all multi-dose bottles and vials on time per week for 2 weeks then more	aff once s will f on  N or s to urred ne	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245537	B. WING		· · · · · · · · · · · · · · · · · · ·	01/2	29/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS,	CITY, STATE, ZIP CODE		
MINNEW	ASKA COMMUNITY I	HEALTH SERVICES		605 MAIN STREET STARBUCK, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	PER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD ERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	opening as the exp off the open date, a upon hire and yearl for dating insulin ar A facility policy titled dated 6/22/09, instruedications maintaproperly labeled in federal regulations, date all multi-dose when opened.  The facility provided	ge 24 were to be dated upon iration date of insulin is based and nurses receive education y regarding the facility policy and other multi-use pens/vials.  Labeling of Medications ucted staff to ensure all tined in the facility were accordance with state and and facility nurses should medications, including insulin, a guide titled, Medication om Consultant Pharmacists	F 4	for 2 months completed by monthly when The results o presented to Assurance C meeting for recommittee for	. Audits will also be y the Pharmacy Consun in the facility. If these audits will be the quarterly Quality committee at the June ecommendations of the further auditing scheed 02/27/2015	2015 ne	
F 458 SS=E	Inc dated 10/08, wh dating of opened H after opening.  In addition, the faci guide titled Medical which directed nursupon opening.  483.70(d)(1)(ii) BEI LEAST 80 SQ FT/F  Bedrooms must me per resident in multileast 100 square feathers.  This REQUIREMED by:  Based on observative review the facility for resident rooms on the strength of the strength	ich indicated the expiration umalog PEN expired 28 days ity also provided a undated ion to date when opened, ing staff to date all insulin DROOMS MEASURE AT	F 4	Waiver Waiver requ 27,28,29, 30, 95.68 to 96.0	Request  ested: in rooms 24.25, 31,31, 33,34, 35, and 37 square feet of usabo not meet the minimu	l 36 are le	<del>2/27/1</del> 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245537	B. WING			01/2	29/2015
	PROVIDER OR SUPPLIER	HEALTH SERVICES		60	TREET ADDRESS, CITY, STATE, ZIP CODE 05 MAIN STREET, PO BOX 40 STARBUCK, MN 56381		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 458	13 of 15 rooms. Tr (R54, R70, R39, R3 R33, R3, R61) who Findings include:  During tour of the A the resident rooms 32, 33, 34, 35 and 3 at least 100 square  On 1/28/15, at 1:37 plenty of space to gwalker, and had no room.  On 1/28/15, at 1:40 be more space in h moving around in th however, she did not contacted a switching rooms.  On 1/28/15, at 1:43 issues with the roor around with no difficulties getting a satisfied.  All rooms were noted decorated.	ais affected 12 of 12 residents 32, R15, R41, R67, R14, R59, resided in the rooms.  -wing on 1/28/15, at 1:30 p.m. 24, 25, 26, 27, 28, 29, 30, 31, 36 were observed to not have feet of useable floor space.  p.m. R54 reported there was get around in the room with the concerns with the size of the p.m. R15 stated there could er room and reported it is hard the room with the wheelchair, of want to switch rooms and anyone in the facility regarding p.m. R39 stated she had no m size and was able to move	F4	58	requirements of at least 100 squar of usable space. Formally complyi bedrooms were reduced in area to accommodate expanded toilet root previous similar waiver was requested.	ing ms. A	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245537	B. WING			01/2	29/2015
	PROVIDER OR SUPPLIER	HEALTH SERVICES		60	TREET ADDRESS, CITY, STATE, ZIP CODE D5 MAIN STREET, PO BOX 40 TARBUCK, MN 56381		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 458	housekeeping servirooms on the A-win able to clean the sp problems.  When interviewed on ursing assistant (Normaller on the A-windifficulties taking caroom sizes, even when utilized.  During interview on facility environment stated the single root than the required 10 space, and the facility environment stated the single root than the required 10 space, and the facility environment stated the single root than the required 10 space, and the facility environment stated the single root than the required 10 space, and the facility environment stated the single root than the required 10 space, and the facility environment stated the single root than the required 10 space, and the facility environment stated the single root than the required 10 space.	ge 26 ices employee stated the g were smaller, but was still bace adequately with no on 1/28/15, at 2:15 p.m. NA)-A stated the rooms are ng, however, there were no ure of residents due to the hen mechanical lifts are  1/28/15, at 2:35 p.m. the al services director (ESD) oms on the A-wing were less 00 square feet of useable floor tity would be applying for a on 1/29/15, at 9:05 a.m. the med the rooms on the A-wing as than 100 square feet of would be applying for the	F4	.58			

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

Printed: 03/09/2015 FORM APPROVED OMB NO. 0938-0391

X3) DATE SURVEY

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - 01 - 1960 BUILDING AND COMPLETED **ADDITIONS** 245537 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 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE TAG OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 000 INITIAL COMMENTS K 000 **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:

(X2) MULTIPLE CONSTRUCTION

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.

(X6) DATE

TITLE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

F5537023

Printed: 02/02/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION
A. BUILDING 02 - 02 - 2004 ADDITIONS

(X3) DATE SURVEY COMPLETED

245537

B. WING

01/26/2015

NAME OF PROVIDER OR SUPPLIER

MINNEWASKA COMMUNITY HEALTH SERVICE

STREET ADDRESS, CITY, STATE, ZIP CODE

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
TAG			CROSS-REFERENCED TO THE APPROPRIATE	DATE
	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:			

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.



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 <u>only a suggestion</u> 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 <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. 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

Minnewaska Community Health Services February 13, 2015 Page 2

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 Weath

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

PRINTED: 03/23/2015 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ B. WING 00477 01/29/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 605 MAIN STREET, PO BOX 40 MINNEWASKA COMMUNITY HEALTH SERVICE STARBUCK, MN 56381 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 \*\*\*\*\*ATTENTION\*\*\*\*\* NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to

**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/inf obul.htm The State licensing orders are delineated on the attached Minnesota

the Department within 15 days of receipt of a notice of assessment for non-compliance.

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 02/19/15

STATE FORM K6L011

TITLE

(X6) DATE

PRINTED: 03/23/2015 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00477	B. WING		01/	29/2015
	PROVIDER OR SUPPLIER	HEALTH SERVICE 605 MAI	DDRESS, CITY, S' N STREET, PO ICK, MN 5638	D BOX 40		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 000	Department of Hearyou electronically, is necessary for Starenter the word "correct. You must then State licensure proceompletion date, the corrected prior to electronic Department on January 26th, 2 surveyors of this Deabove provider and orders are issued. electronic plan of correviewed these ord they will be completed they will be completed. Minnesota Department of the State Licensing federal software. The assigned to Minnesota Department of the State Licensing federal software. The assigned to Minnesota Department of the State Licensing federal software. The assigned to Minnesota Department of the State Licensing federal software. The assigned tag in column entitled "ID statute/rule out of computer the statement of the Suggested Time period for Corplease DISREGA FOURTH COLUMN	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health.  27th, 28th and 29th 2015, epartment's staff, visited the the following correction Please indicate in your prection that you have ers, and identify the date where the following correction Orders using ag numbers have been noted state statutes/rules for umber appears in the far left of Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the nis column also includes the n violation of the state statute, "This Rule is not met as wing the surveyors findings Method of Correction and crection.  ARD THE HEADING OF THE WHICH STATES,				
		N OF CORRECTION." THIS				

Minnesota Department of Health

STATE FORM 6899 K6L011 If continuation sheet 2 of 32

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00477	B. WING		01/2	9/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MINNEW	ASKA COMMUNITY F	IFAL IH SERVICE	STREET, P CK, MN 5638			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	THIS WILL APPEAR ON EACH PAGE.					
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train		2 302			2/27/15
	ALZHEIMER'S DIS DISORDER TRAIN MN St. Statute 144					
	Alzheimer's disease or related of segregated or gene care staff	ity serves persons with disorders, whether in a eral unit, the facility's direct rs must be trained in dementia				
	related disorders; (2) assistance with (3) problem solving and (4) communication (c) The facility shall written or electronic training program, th trained, the frequer topics covered.	of Alzheimer's disease and activities of daily living; with challenging behaviors;				
	This MN Requireme	ent is not met as evidenced				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				7.1. 20123.110.			
		00477		B. WING		01/2	9/2015
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
MINNEW	ASKA COMMUNITY I	HEALTH SERVICE		STREET, P K, MN 5638			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 302	Continued From pa	ige 3		2 302			
	by: Based on interview facility failed to prove training for 1 of 4 n for 2 of 2 licensed part LPN-D) who provide addition, the facility (family and/ or resident the potential to resided in the facility Findings include:  LPN-D was hired or record lacked evident Alzheimer's training	and document review, the vide the required Alzheim ursing assistants (NA-D) practical nurses (LPN-C, ded direct care services. If alled to provide consumdents) with written inform the imer's training program. If affect all 60 residents with and their families.  In 10/13/14. The employed ence of recieving the required.	ner's and In ners ation This ho		Acknowledged		
		10/27/14. The employed ence of recieving the requ g.					
	LPN-C was hired o record lacked evide Alzheimer's training	n 10/16/14. The employence of recieving the requ g.	ee uired				
	director of nursing	n 1/27/15, at 3:11 p.m. the (DON) verified the above the required Alzheimer's					
	verified consumers regarding the facilit program. The SSD residents admitted unit are only inform	variable 1/27/15, at 3:18 p.m. SS were not provided inform by staff Alzheimer's training stated the families of to the (Alzheimer's) dem and of the criteria to be can dear and providing any formally training.	nation ng entia				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00477	B. WING	<del> </del>	01/2	9/2015
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MINNEW	ASKA COMMUNITY H	HEALTH SERVICE	STREET, P CK, MN 5638			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 302	Continued From pa	ge 4	2 302			
	A policy regarding the faciltiy Alzheimers training was requested but not provided.					
	The director of nurs implement policies required Alzheimer' requirements. The	quality assessment and ee could perform random				
	TIME PERIOD FOR days.	R CORRECTION: Twenty (21)				
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			2/27/15
		omprehensive plan of care I personnel involved in the i.				
	by: Based on observati review, the facility fa	ent is not met as evidenced ion, interview, and document ailed to follow the written care nterventions for 1 of 4 iewed.		Acknowledged		
	Findings include:					
	1/13/15, identified F impairment, require	imum Data Set (MDS) dated R58 had severe cognitive ed total staff assistance for all (ADL), and had sustained a				

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 5 of 32 K6L011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00477		B. WING		01/	29/2015
NAME OF	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MINNEW	/ASKA COMMUNITY F	HEALTH SERVICE		STREET, P K, MN 5638			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE  / MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 565	65 Continued From page 5		2 565				
	a risk of falls and retransfers and mobil staff to reduce the reto ensure resident with seatbelt at all temeals. The care plethe resident back in seatbelt after R58 v. During observation was not transferred the seat belt after bein the tall wheel chafront of the bird avia monitoring R58 in the not equipped with the continuous observation wheel chair without be used for meal tirestaff had walked by resident was not in safety belt attached	on 1/29/15, at 8:15 at to the low wheel chareakfast, and was brair without a seat beltary. No staff had been tall wheel chair whe seat belt. During ation, R58 remained a seat belt which warne. Although several R58, staff did not id the low wheelchair wh	ith structed from falls neel chair of when at transfer ir with the a.m. R58 air with rought out to sit in en hich was in the tall as only to al nursing entify the with the sed to be				
	verified the tall whe seated in unsuperv	1/29/15, at 9:05 a.m el chair which R58 h ised did not have a s used when R58 was vision of staff.	ad been eat belt,				
	NA-H placed R58 i the resident was se	on 1/29/2015, at 11: n front of the bird av tated in the tall whee it, and walked away t	iary while I chair				
	During interview on	1/29/2015, at 11:12	a.m.				

Minnesota Department of Health

STATE FORM 6899 K6L011 If continuation sheet 6 of 32

PRINTED: 03/23/2015 FORM APPROVED

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00477	B. WING		01/2	9/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
MINNEW	/ASKA COMMUNITY H	HEALTH SERVICE	STREET, P K, MN 5638			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 565	registered nurse (Runsupervised in the equipped with the sof time, and stated, absolutely would nowheel chair without R58's care plan ins resident was in the seatbelt on at all time. During interview on stated R58 utilized was higher and use was lower to the grand-lead forward in the resident was cas wheelchair with the During interview on director of nursing assessed to have to the chair and a seat be falling forward out of would expect staff to the facility policy time. The facility policy time in the comprehensive to Enhance the optimisers of nursing to Enhance the optimisers of the comprehensive to Enhance the optimisers of the policies ensuring staff implement policies ens	in)-A verified R58 had been wheel chair which was not seat belt for extended periods "On a normal day, [R58] ot," be unsupervised in the tall the seatbelt. RN-A stated tructed staff to ensure the low wheelchair with the nes, except when eating.  1/28/2015, at 1:00 p.m. NA-I two different wheel chairs; one of for meals, and the other ound and had a seat belt on it. as a fall risk because she er wheelchair, which is why are planned to be in a low seat belt.  1/29/2015, at 2:49 p.m. the (DON) stated R58 was the low to the ground wheel all to prevent the resident from of her wheelchair, and she is follow R58's care planned.  Itled Care sive dated 5/3/12, identified to care plan has been designed imal functioning of the	2 565			

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00477	B. WING		01/2	9/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MINNEW	ASKA COMMUNITY H	IFAL I H SERVICE	STREET, P K, MN 5638			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 565	Continued From page 7		2 565			
21426	days.	R CORRECTION: Twenty (21)	21426			2/27/15
21420	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control		21420			2/2//15
	(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.					
	by: Based on interview facility failed to emp Screening and Tub medical evaluations	ent is not met as evidenced and document review, the bloyee Tuberculosis (TB) erculin Skin Testing (TST) and s were completed for 4 of 5 , NA-D, DA-A and DA-B) tact.		Acknowledged		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00477		B. WING		01/2	29/2015
	PROVIDER OR SUPPLIER	IFALTH SERVICE 60	05 MAIN	ORESS, CITY, S STREET, P SK, MN 5638			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO	LL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21426	Continued From pa	ge 8		21426			
	employee file indicated The Employee Tuber completed 10/8/14, There was no evide been administered.  A review of nursing file indicated a hire Employee Tubercul 10/20/14, along with was no evidence a administered.  A review of dietary a indicated a hire date Employee Tubercul 12/2/14, along with	d practical nurse (LPN)- ated a hire date of 10/13 erculosis Screening was along with the first step ence a second step TST  g assistant (NA)-D employ date of 10/27/14. The osis Screening was cor the first step TST. Th second step TST had b  associate (DA)-A employ e of 12/13/14. The osis Screening was cor the first step TST. The nd step TST had been	3/14. s o TST. had oyee mpleted ere een oyee file mpleted				
	file indicated a hire Employee Tubercul 11/7/14, along with	associate (DA)-B emplo date of 11/10/14. The osis Screening was cor the first step TST. The nd step TST had been	npleted				
	director of nursing (DA-A and DA-B did TST. The DON sta problem [employee TST], and believed	1/29/2015 at 8:33 a.m. DON) stated LPN-D, Nonot receive the second ted she knew this was as receiving the second sit was due to staff not know a get the second step To	A-D, l step a step ceeping				

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00477	B. WING		01/2	9/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET F	DDRESS, CITY, S	STATE, ZIP CODE		
MINNEW	ASKA COMMUNITY H	HEALTH SERVICE	N STREET,  P ICK, MN  5638			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21426	During interview on registered nurse (R start work until they and 2-3 weeks latereceive the second. The facility policy till Health Services Tul Assessment form comployees and volution-step mantoux [The facility policy till Employees/Volunte indicated upon employees/Volunte indicated upon employees and volution to be adminifirst step.  SUGGESTED MET The director of nursimplement policies completing employed the quality assess committee could peensure compliance.	in 1/29/2015, at 11:11 a.m. in 1/29/2015, at 12:11 a.m. it is required to step TST.  Itled Minnewaska Community berculosis Control Plan/Risk in 1/29/2015, and 1/2/14, indicated all new unteers will have an initial TST].  Itled Tuberculosis Screening of the property of the p				
21530	days.  MN Rule 4658.1310	0 A.B.C Drug Regimen Revie	v 21530			2/27/15
	reviewed at least m currently licensed b This review must be Appendix N of the S	en of each resident must be nonthly by a pharmacist by the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00477	B. WING		01/2	9/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		605 MAIN	STREET, P			
MINNEW	ASKA COMMUNITY H	STARBUC	K, MN 5638	31		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21530	Continued From page 10		21530			
21530	Requirements in Lot the Department of I Health Care Finance This standard is incomply available through the system. It is not sure B. The pharma irregularities to the and the attending properties to the and the attending properties. For purpon means the acreport and the signification of nursing services. C. If the attend with the pharmacist not provide adequate pharmacist believes being adversely after the matter to the attending physician. If the method attending physician does not must be referred for assessment and as by part 4658.0070, the medical direct must refer the mattassessment and as assessment and as a service of the service	ong-Term Care, published by Health and Human Services, sing Administration, April 1992. Corporated by reference. It is ne Minitex interlibrary loan bject to frequent change. It is ne Minitex interlibrary loan bject to frequent change. It is ne Minitex interlibrary loan bject to frequent change. It is ne Minitex interlibrary loan bject to frequent change. It is new to frequent change. It is not the next conner, if indicated by the proses of this part, "acted compared to the ingorinitialing by the director and the attending physician. In the ingorinitial physician does not concurt the resident's quality of life is extend the pharmacist must the medical director for review to ris not the attending edical director determines that coin does not have adequate order and if the attending change the order, the matter or review to the quality essurance committee required. If the attending physician is or, the consulting pharmacist er directly to the quality essurance committee.	21530			
	Based on observation review, the facility of ensure 1 of 3 reside	on, interview, and document consulting pharmacist failed to ents (R22), who were taking d antidepressant medication,		Acknowledged		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00477	B. WING	·····	01/2	9/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MINNEW	ASKA COMMUNITY F	IEVI I B SEBVICE	STREET, P CK, MN 5638			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21530	Continued From pa	ge 11	21530			
	had justification for	use.				
	Findings include:					
	10/22/14, identified	m Data Set (MDS) dated R22 had no cognitive If no behaviors during the				
	1/2015, identified R antidepressant med 8/23/14, 15 milligran	rrent medication orders dated 22 received Remeron (an lication), with a start date of ms daily (mg) daily, and rehotic medication), with a 15, 2.5 mg daily.				
		edical record lacked lentified target behaviors e Remeron or Zyprexa.				
	Pharmacist's Medic identified monthly d consulting pharmac medication, however recommendations r	er, there was no pharmacist egarding target behaviors, ions, or indications for use of				
		on 1/28/2015, at 11:55 a.m. cop of the covers in bed with and lights off.				
	R22 had been seate with four other male conversation with the	on 1/28/2015, at 6:31 p.m. ed in the dining room, eating e residents. R22 engaged ne other male residents seated ted his meal, and stacked the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00477	B. WING		01/2	29/2015
NAME OF	PROVIDER OR SUPPLIER		ADDRESS, CITY,	STATE, ZIP CODE		
MINNEW	ASKA COMMUNITY F	HEALTH SERVICE	JCK, MN 5638			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21530	Continued From pa	ge 12	21530			
	nursing assistant (N	01/29/2015, at 10:26 a.m. NA)-C stated R22 had, vior of refusal to get washed				
	registered nurse (R had behaviors of re device to alert staff however, R22 no lo bracelet because houlding without stared R22's record lacked Zyprexa and Reme behavioral interventions of the start of	1/29/2015, at 10:52 a.m. N)-A stated R22 previously fusing to wear a code alert (a of a resident leaving), anger required the code alert e no longer tried to exit the ff knowledge. RN-A verified d target behaviors for the ron, did not have any tions for staff to try for any ed, and RN-A stated R22 did liagnosis for the use of on.				
	director of nursing ( protocol for the use included identifying interventions, along	1/29/2015, at 1:48 p.m. the (DON) verified the expected of antipsychotic medication target behaviors and with ongoing monitoring of by tracking the episodes of				
	the facility consulting behaviors, intervendocumentation should be Remeron and Zypre	erview on 1/29/15, at 4:30 p.m og pharmacist stated target tions, justification for use, and uld be in place for use of exa, and stated especially for eiving these medications, "No shosis."	t l			
	Medication Review	policy titled Psychotropic identified staff must consider eted symptoms and behavior				

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STATEMENT OF DEFICIENCIES (X1)

AND DUAN OF CODDECTION IDENTIFICATION NUMBER.		1 ` '			DATE SURVEY COMPLETED	
7.1.12 . 2.11.	o. co		A. BUILDING:			
		00477	B. WING		01/2	29/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
MINNEW	ASKA COMMUNITY I	HEALTH SERVICE	N STREET, P CK, MN 5638			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21530	Continued From pa	age 13	21530			
	The director of nurs develop and impler related to consultin irregularities. The cassurance committe audits to ensure continuous TIME PERIOD FOR days.	R CORRECTION: Twenty (21				
21535	Subpart 1. General must be free from unnecessary drug in A. in excessive therapy; B. for excessive therapy; B. for excessive therapy; C. without adea D. in the prese which indicate the odiscontinued. In addition to the discontinued. In addition to the discontinued in addition to the discontinued. In addition to the discontinued in th	al. A resident's drug regimen unnecessary drugs. An is any drug when used: e dose, including duplicate drug				2/27/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00477	B. WING	<del></del>	01/2	9/2015
	PROVIDER OR SUPPLIER	HEALTH SERVICE 605 MAIN	DDRESS, CITY, STREET, F			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21535	Continued From pa		21535			
	by: Based on observati review, the facility for indications for use of antidepressant med	ent is not met as evidenced on, interview, and document ailed to identify clinical of an antipsychotic and dication for 1 of 3 resident or received an antipsychotic medication.		Acknowledged		
	10/22/14, identified impairment and had	m Data Set (MDS) dated R22 had no cognitive d no behaviors during the				
	1/2015, identified R antidepressant med 8/23/14, 15 milligra	rrent medication orders dated 22 received Remeron (an dication), with a start date of ms daily (mg) daily, and vehotic medication), with a				
	documentation of ic	edical record lacked dentified target behaviors e Remeron and Zyprexa or eventions which may be				
		on 1/28/2015, at 11:55 a.m. top of the covers in bed with and lights off.				
	R22 was seated in four other male res	on 1/28/2015, at 6:31 p.m. the dining room eating with idents. R22 engaged in ne other male residents seated				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00477	B. WING		01/2	29/2015
	PROVIDER OR SUPPLIER	HEALTH SERVICE 605 MAIN	DRESS, CITY, S STREET, POCK, MN 5638			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21535	at his table, complet dishes together.  During interview on nursing assistant (Noccasional" behaviors.  During interview on registered nurse (Robat had behaviors of redevice to alert staff however, R22 no lobracelet because hwithout staff knowler record lacked target of Zyprexa and Rerinterventions for state determined, and Robat proper diagnosis for Remeron.  During interview on director of nursing (protocol of the use included identifying interventions, along the target behaviors any behaviors.  During a phone interview on director of nursing (protocol of the use included identifying interventions, along the target behaviors.  During a phone interview documentation sho Remeron and Zyprethose residents reconspecifically for psyconal control of the undated facility.	ted his meal, and stacked the 01/29/2015, at 10:26 a.m. NA)-C stated R22 had, viors of refusal to get washed 1/29/2015, at 10:52 a.m. N)-A stated R22 previously fusing to wear a code alert (a of a resident leaving), unger required the code alert e didn't try to exit the building edge. RN-A verified R22's at behaviors justifying the use meron, nor any behavioral aff to try for any behaviors N-A stated R22 did not have a r the use of Zyprexa or 1/29/2015, at 1:48 p.m. the (DON) verified the expected of antipsychotic medication target behaviors and with ongoing monitoring of s by tracking the episodes of erview on 1/29/15, at 4:30 p.m. ag pharmacist stated target tions, justification, and uld be in place for use of exa, and stated especially for eiving these medications, "Not	21535			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

			(X3) DATE COMP	SURVEY PLETED		
			A. BOILDING.			
		00477	B. WING		01/2	29/2015
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MINNEW	ASKA COMMUNITY H	HEALTH SERVICE	STREET, P K, MN 5638			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21535	Continued From pa	ge 16	21535			
	and document targe of concern.	eted symptoms and behaviors				
	The director of nurs develop and implen related to continued the elderly. The qu	THOD FOR CORRECTION: sing (DON) or designee could nent policies and procedures d use of antipsychotic use in ality assessment and ee could perform random mpliance.				
	TIME PERIOD FOR days.	R CORRECTION: Twenty (21)				
21620	MN Rule 4658.1345	5 Labeling of Drugs	21620			2/27/15
	Drugs used in the rin accordance with	nursing home must be labeled part 6800.6300.				
	by: Based on observati review, the facility fa were dated when of was not expired for	ent is not met as evidenced on, interview, and, document ailed to ensure insulin pens pened to ensure medication 1 of 1 resident, R48, who was insulin which had not been d.		Acknowledged		
	Findings include:					
	the D-wing was obs nurse (LPN)-A. The insulin flex pen for I when it was opened pharmacy label with	9 p.m. the medication cart for served with licensed practical ere was a half full Humalog R48 which had no date on d. The insulin pen had a n a delivery date to the facility A confirmed staff were				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00477	B. WING	·····	01/2	9/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
MINNEW	ASKA COMMUNITY H	IFAL I H SERVICE	STREET, P K, MN 5638			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21620	opened to ensure reinsulin which is expletermine when the for R48.  R48's January 2018 Record (MAR) indice Humalog insulin bathood glucose level undated Humalog in evenings.  During interview on director of nursing (was all insulin pensopening as the explosif the open date, a upon hire and yearl for dating insulin and A facility policy titled dated 6/22/09, instrumedications maintal properly labeled in a federal regulations, date all multi-dose in when opened.  The facility provided Expiration Dating from Inc dated 10/08, who dating of opened Heafter opening.  In addition, the facility guide titled Medications in addition, the facility guide titled Medications.	ge 17 I insulin pens when they are esidents are not receiving ired, and LPN-A was unable to e insulin pen had been opened  5, Medication Administration cated R48 was to receive the sed on a sliding scale of his and had received the nsulin on all but three  01/27/15, at 2:19 p.m. the DON) stated her expectation were to be dated upon iration date of insulin is based and nurses receive education y regarding the facility policy dother multi-use pens/vials.  I Labeling of Medications ucted staff to ensure all ined in the facility were accordance with state and and facility nurses should medications, including insulin,  I a guide titled, Medication om Consultant Pharmacists iich indicated the expiration umalog PEN expired 28 days  ity also provided a undated ion to date when opened, ing staff to date all insulin	21620			

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AND DUAN OF CODDECTION IDENTIFICATION NUMBER.					SURVEY LETED	
			A. BUILDING.			
		00477	B. WING		01/2	9/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MINNEW	ASKA COMMUNITY H	HEALTH SERVICE	STREET, P CK, MN 5638			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
21620	Continued From pa	ge 18	21620			
	The director of nursimplement policies labeling medication necessary such as assessment and as perform random au	THOD FOR CORRECTION: sing (DON) could develop and and procedures related to s when opened when insulin. The quality ssurance committee could dits to ensure compliance.				
	days.	(L)				
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			2/27/15
	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.					
	by: Based on observati review the facility fa	ent is not met as evidenced on, interview, and document alled to promote dignity related of for 1 of 1 resident (R2) who gnity.		Acknowledged		
	Findings include:					
	R2 had diagnoses of extremities, brain in careplan identified impairment, require complete all activition including requiring of	lan dated 12/16/14, identified of hemiplegia affecting his left njury, and epilepsy. The R2 had moderate cognitive and assistance from staff to es of daily living (ADL), extensive assistance grooming his of his left side, and				

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		00477	B. WING		01/2	29/2015
	PROVIDER OR SUPPLIER	HEALTH SERVICE 605 MAIN	DRESS, CITY, S STREET, P CK, MN 5638			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21805	indicated he prefers for all meals.  During observation was sitting in his what a tan brown food substant R2's face, while the to run down his chirupper chest area of which consisted of toast, and the tan been dripping down have food on his fact to the dining room food substant R2's face, while the to run down his chirupper chest area of which consisted of toast, and the tan been dripping down have food on his fact to the dining room food on his fact to the dining room by ped right foot, and using wheelchair out of the assistant (NA)-E cat assisted R2 to the activities director (Abrought R2 to his rep.m. R2 continued that a red, moist su side of his face from to his mustache, and at 12:39 p.m. on 1/2 entered R2's room use the bed pan and call light and the aid.	on 1/27/15, at 11:12 a.m. R2 neelchair watching t.v. R2 had ubstance on the right side of m the corner of his mouth, all om of his chin. Some of the tan nee was dry and crusted onto tan food substance continued in area onto his shirt. The right R2's shirt had food on it some cheerios, crumbs of rown food substance that had in his chin. R2 continued to ce and clothing until he went				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			A. BOILDING.			
		00477	B. WING		01/2	9/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
MINNEW	ASKA COMMUNITY I	HEALTH SERVICE	ISTREET, P CK, MN 5638			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21805	Continued From pa	age 20	21805			
	to assist the reside assisting R2 with per the residents room have the a red, more the left side of his frouth to his mid charache area.  At 3:05 p.m. R2 was itting in the fireside the red moist substitute red moist substitute of his face from his mid chin area a	and NA-F entered R2's room nt off the bedpan. After ericare, NA-E and NA-F left at 1:30 p.m. R2 continued to ist substance running down ace from the corner of his hin area and along his as in his wheelchair and was e room. R2 continued to have tance running down the left m the corner of his mouth to along his mustache area.				
	stated R2 always h meals, and his shir at times. NA-E stat R2's face and cloth	as food on his face after t also gets dirty during meals ed staff should be cleaning hing after meals and stated, hat this [having food on his face				
	registered nurse (F stuck in his mustac mouth. RN-B verifi his shirt and cleani	n 1/29/15, at 10:41 a.m. RN)-B stated R2 often had food the and in the corners of his lied staff should be changing his face, and also stated it for the resident to have food left lies after dining.				
	of nursing (DON) s food on his face an expect staff to wipe water, change his c oral cares. The DO	n 1/29/15, at 11:01 a.m. director tated she has seen R2 with ad clothing and she would be his face, give him a drink of clothes if needed, and provide by agreed it is not promoting by to leave food on his mouth				

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:	·	COMP	LEIED
		00477	B. WING		01/2	9/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
MINNEW	/ASKA COMMUNITY H	HEALTH SERVICE	ISTREET, P CK, MN 5638			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21805	Continued From pa	 age 21	21805			
	2/2014, directed sta	olicy titled Courtesy dated aff to treat resident's, their and fellow workers with and dignity.				
	The DON or design providing dignified of designee could the to ensure residents are being maintained.	THOD OF CORRECTION: nee could educate staff on care to residents. The DON or in interview residents routinely sefeel their dignity and respect ed.  R CORRECTION: Twenty One				
	(21) days.	t contract thomy one				
21990	MN St. Statute 626 Maltreatment of Vu	5.557 Subd. 4 Reporting - Ilnerable Adults	21990			2/27/15
	immediately make a entry point. Use of for the deaf or othe considered an oral point may not requiextent possible, the content to identify the caregiver, the nature maltreatment, any emaltreatment, the reporter, the time, coincident, and any of reporter believes must be suspected malter reporter may disclossible.	an oral report to the common a telecommunications device er similar device shall be report. The common entry ire written reports. To the ereport must be of sufficient the vulnerable adult, the re and extent of the suspected evidence of previous name and address of the date, and location of the ther information that the night be helpful in investigating treatment. A mandated ose not public data, as defined and medical records under				

Minnesota Department of Health

A. BUILDING:	
<b>00477</b> B. WING	
NAME OF PROVIDER OR SUPPLIER  MINNEWASKA COMMUNITY HEALTH SERVICE  STREET ADDRESS, CITY, STATE  605 MAIN STREET, PO BO STARBUCK, MN 56381	E, ZIP CODE
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE
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.	knowledged

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00477	B. WING	·	01/2	29/2015
	PROVIDER OR SUPPLIER	HEALTH SERVICE 605 MAIN	I STREET, P			
IVIII VI	ASKA OOMMONITTI	STARBU	CK, MN 5638	31		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21990	During interview on practical nurse (LPI bruising R37 had, be the Progress Notes medical record, LPI was a bruise under aware of the cause seen the bruise, show the bruise, show the progress on registered nurse (R had reported R 37 left breast. RN-A significant how the bruise happassessment including report of the bruise made to the state a and no investigation stated when a residunknown origin, staresident how it happif the cause of the bareport would be fire RN-A stated she had R37's bruising and mechanical lift sling did not observe the document any investigated she gave R3	1/29/15, at 9:53 a.m. licensed N)-A was not aware of any but stated she would look at . After consulting R37's N-A stated it appeared there R37's breast. LPN-A was not , and although she had not e stated it could possibly have shanical lift sling. LPN-A uise was discovered on to the Progress Notes.  1/29/15, at 9:56 a.m. N)-A stated on 1/27/15, staff and a large bruise under her tated no one was aware of pened, there was no physical ng measuring of the bruise, no of unknown origin had been gency and/or administrator, in had been started. RN-A lent had a bruise/ injury of ff is instructed to ask the pened, assess the injury, and bruise or injury was unknown, led with the state agency. In the state agency and talked to aides regarding she felt it was due to the late of the bruising, nor did she stigation or interviews.				
	NA-C and LPN-A tr	on 1/29/15, at 10:08 a.m. ansferred R37 from the				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION  a:		(X3) DATE SURVEY COMPLETED	
		00477	B. WING		01/3	29/2015
	PROVIDER OR SUPPLIER  ASKA COMMUNITY F	IFALTH SERVICE 60	REET ADDRESS, CITY, 5 MAIN STREET, FARBUCK, MN 563	PO BOX 40		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21990	R37's bruising. RN device to measure lateral left breast, w (centimeters) x 7 cr bruising on R37's h older bruises and s R37 bumping the tanot cognitive enough happened. RN-As was possibly causes sling, but could not report the bruise of of nursing (DON) so state agency and at During interview on DON stated she was bruising of unknown stated staff are expreports on all bruise cause is not known immediately contact make the initial report then begin the investigate.  During interview on administrator confir R37's bruise of unknown administrator and s investigate.  The facility undated Resident Accidents to report all injuries	was in the room to asset -A used a paper measure a dark, purple bruise on thich measured 6 cmm. RN-A stated the smaland and lower arms well he believed they came fuble. RN-A stated R37 that the believed they came for the sure, and she was gunknown origin to the dot a report can be made in investigation could be a rorigin for R37. The Dot ected to complete incides of unknown origin, an staff are expected to the state agency, and the state agency and the state agency, and the state agency are stated as a state agency.	ring R37's aller re rom was se ruise ift oing to irector to the gin. the e DN ent d if the N, and and the of stated all he			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		00477	B. WING		01/2	9/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
MINNEW	ASKA COMMUNITY H	HEALTH SERVICE	NSTREET, P CK, MN 5638			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21990	Continued From pa	nge 25	21990			
	investigation.					
	3					
	The director of nurs develop and implent related to immediat agency, the administ thorough investigat The quality assessing	THOD FOR CORRECTION: sing (DON) or designee could ment policies and procedures tely reporting to the state strator and completing a ion for vulnerable adult cases. ment and assurance erform random audits to .				
	TIME PERIOD FOR days.	R CORRECTION: Twenty (21)				
21995	MN St. Statute 626 Maltreatment of Vu	.557 Subd. 4a Reporting - Inerable Adults	21995			2/27/15
	(a) Each facility shongoing written proapplicable licensing of suspected maltrefacility has an intermandated reporter requirements of this internally. However	Il reporting of maltreatment. all establish and enforce an ocedure in compliance with grules to ensure that all cases eatment are reported. If a nal reporting procedure, a may meet the reporting s section by reporting r, the facility remains applying with the immediate ents of this section.				
	by: Based on observati review, the facility for prohibition policies reporting to the facility for the facil	ent is not met as evidenced ion, interview, and document ailed to implement their abuse and procedures for immediate ility administrator and state corough investigations for 1 of		Acknowledged		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00477	B. WING		01/	29/2015
	PROVIDER OR SUPPLIER	HEALTH SERVICE 605 MAIN	DDRESS, CITY, S N STREET, P CK, MN 5638			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21995	1 resident (R37) with Findings include:  The facility undated Resident Accidents to report all injuries appropriate state agfacility administrato investigation.  R37's annual Minim 11/6/14, identified Fimpairment, require for all areas of daily mechanical standin staff for all transfers.  R37's care area ass 11/12/14, identified dementia with Lewy Parkinson's Diseas staff to anticipate no decisions regarding.  Review of R37 Progindicated R37 had I left shoulder, and h.  During interview on assistant (NA)-B standard that R37 had which was not new, from the resident be aware of any other she noted bruising anurse immediately.  During interview on in	th a bruise of unknown origin.  I Reporting/Investigating //Incidents policy, directed staff of unknown source to gencies promptly, report to the r, and conduct a thorough num Data Set (MDS) dated a37 had severely cognitive ed extensive staff assistance viving (ADL), and required a g lift and assistance of two sessment (CAA) dated R37 had diagnoses including v bodies and progressing e, and R37 was dependent on eeds and rarely/never made y daily tasks of life.  Gress Notes dated 1/27/15, arge bruises under left breast, and.  1/29/15, at 9:48 a.m. nursing ated the only bruise she was a was a bruise on her left hand, and NA-B thought it came umping the table. NA-B not bruising R37 had, however, if she would report it to the				
	practical nurse (LPI	N)-A was not aware of any				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00477	B. WING		01/2	9/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
MINNEV	/ASKA COMMUNITY H	HEALTH SERVICE	STREET, P CK, MN 5638			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21995	bruising R37 had, be the Progress Notes medical record, LPI was a bruise under aware of the cause seen the bruise, she come from the mediconfirmed R37's bruizing interview on registered nurse (R had reported R 37 left breast. RN-A show the bruise hap assessment including report of the bruise made to the state a and no investigation stated when a residunknown origin, staresident how it hap if the cause of the barresident how it hap as a second how it hap if the cause of the barresident how it hap as a second how it hap as	out stated she would look at a. After consulting R37's N-A stated it appeared there R37's breast. LPN-A was not and although she had not e stated it could possibly have chanical lift sling. LPN-A uise was discovered on to the Progress Notes.  1/29/15, at 9:56 a.m. 1/29/15, at 10:07 a.m. NA-C ar a bath on 1/27/15, and ruise under the residents left	21995			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
		00477	B. WING		01/2	9/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MINNEW	/ASKA COMMUNITY H	IFAL IH SERVICE	STREET, P K, MN 5638			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21995	device to measure lateral left breast, w (centimeters) x 7 cu bruising on R37's holder bruises and s R37 bumping the tanot cognitive enough happened. RN-As was possibly cause sling, but could not report the bruise of of nursing (DON) sistate agency and a During interview on DON stated she was bruising of unknows stated staff are expreports on all bruise cause is not known immediately contact make the initial reputhen begin the inverse During interview on administrator confir R37's bruise of unknown administrator and sinvestigate.  SUGGESTED MET The director of nurse develop and implement adult policy. The contact of the contact	a dark, purple bruise on R37's which measured 6 cm m. RN-A stated the smaller and and lower arms were the believed they came from able. RN-A stated R37 was that to recall how the bruise tated she believed the bruise dated she was going to unknown origin to the director of a report can be made to the nation investigation could begin.  O1/29/15, at 10:19 a.m. the as not made aware of the nation origin for R37. The DON ected to complete incident the sof unknown origin, and if the staff are expected to the administrator, DON, and out to the state agency, and stigation.  O1/29/15, at 10:34 a.m. the med he was not aware of nown origin which was valued to immediately report all no origin immediately to the tate agency, and then  THOD FOR CORRECTION: Sing (DON) or designee could ment policies and procedures and p	21995			

Minnesota Department of Health

STATE FORM 6899 K6L011 If continuation sheet 29 of 32

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
		00477	B. WING		01/2	9/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MINNEW	ASKA COMMUNITY H	IFAL IH SERVICE	STREET, P K, MN 5638			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETE DATE
21995	Continued From page 29		21995			
	TIME PERIOD FOR CORRECTION: Twenty (21) days.					
22155	MN Rule 4658.4109 New Construction	5 Subp. 2 Bedroom Design;	22155			2/27/15
	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.					
	by: Based on observatireview the facility faresident rooms on tleast 100 square fer 13 of 15 rooms. Trooms, R70, R39, R30, R30, R30, R30, R30, R30, R30, R30	on, interview, and document illed to ensure the single the A-wing of the facility had at et of useable floor space for its affected 12 of 12 residents 32, R15, R41, R67, R14, R59, resided in the rooms.		Acknowledged		
	Findings include:					
	the resident rooms 32, 33, 34, 35 and 3	24, 25, 26, 27, 28, 29, 30, 31, 36 were observed to not have feet of useable floor space.				
	On 1/28/15, at 1:37	p.m. R54 reported there was				

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-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00477	B. WING		01/2	9/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MINNEW	ASKA COMMUNITY H	HEALTH SERVICE	STREET, P CK, MN 5638			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
22155	Continued From pa	ge 30	22155			
		et around in the room with the concerns with the size of the				
	be more space in h moving around in th however, she did no	p.m. R15 stated there could er room and reported it is hard ne room with the wheelchair, ot want to switch rooms and anyone in the facility regarding				
		p.m. R39 stated she had no m size and was able to move culty.				
		p.m. R32 stated he was with his room, had no				
		p.m. R70 stated she had no round her room and was				
	All rooms were note decorated.	ed to all be clean, orderly, and				
	housekeeping serving rooms on the A-win	on 1/28/15, at 2:00 p.m. the ices employee stated the g were smaller, but was still pace adequately with no				
	nursing assistant (N smaller on the A-wi difficulties taking ca room sizes, even w utilized.	on 1/28/15, at 2:15 p.m. NA)-A stated the rooms are ng, however, there were no are of residents due to the then mechanical lifts are				
	During interview on	1/28/15, at 2:35 p.m. the				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00477	B. WING		01/2	9/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	SHOULD BE COMPLETE		
22155	Continued From page 31		22155				
	facility environment stated the single root than the required 10 space, and the facili room wavier.  When interviewed of administrator confinct to have less usable space and waiver again.  SUGGESTED MET The administrator of waiver and monitor ongoing basis for second the state of the state	al services director (ESD) oms on the A-wing were less 00 square feet of useable floor tiy would be applying for a on 1/29/15, at 9:05 a.m. the med the rooms on the A-wing as than 100 square feet of would be applying for the THOD FOR CORRECTION: could apply for the federal identified rooms on an afety and resident satisfaction. ment and assurance					
	ensure compliance	erform random audits to R CORRECTION: Twenty (21)					
	aays.						