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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: KI83

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00629

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245325**

2.STATE VENDOR OR MEDICAID NO.
(L2) **781843200**

3. NAME AND ADDRESS OF FACILITY
(L3) **FOLEY NURSING CENTER**
(L4) **253 PINE STREET**
(L5) **FOLEY, MN** (L6) **56329**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/15/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **89** (L18)

13.Total Certified Beds **89** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	89			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Jessica Sellner, Unit Supervisor — 07/15/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 07/29/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/08/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245325
July 29, 2015

Ms. Heather Meixner, Administrator
Foley Nursing Center
253 Pine Street
Foley, Minnesota 56329

Dear Ms. Meixner:

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 June 30, 2015 the above facility is certified for or recommended for:

89 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 89 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
July 29, 2015

Ms. Heather Meixner, Administrator
Foley Nursing Center
253 Pine Street
Foley, Minnesota 56329

RE: Project Number S5325024

Dear Ms. Meixner:

On June 18, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 4, 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 July 15, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard extended survey, completed on June 4, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 30, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 4, 2015, effective June 30, 2015 and therefore remedies outlined in our letter to you dated June 18, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245325	A. Building B. Wing	7/15/2015

Name of Facility	Street Address, City, State, Zip Code
FOLEY NURSING CENTER	253 PINE STREET FOLEY, MN 56329

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 **F0160** Reg. # **483.10(c)(6)** LSC	Correction Completed **06/12/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **06/30/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **06/30/2015**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **06/30/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	JS/KJ	07/29/2015	29249	07/15/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
6/4/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: KI83

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(L2) **781843200**

3. NAME AND ADDRESS OF FACILITY
(L3) **FOLEY NURSING CENTER**
(L4) **253 PINE STREET**
(L5) **FOLEY, MN** (L6) **56329**

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/04/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)

0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **89** (L18)

13.Total Certified Beds **89** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	89			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Annette Truebenbach, HFE NE II 06/29/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 07/07/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

Posted 07/08/2015 Co.
DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 0470 0000 5262 1796

June 18, 2015

Mr. Steven Oelrich, Administrator
Foley Nursing Center
253 Pine Street
Foley, Minnesota 56329

RE: Project Number S5325024

Dear Mr. Oelrich:

On June 4, 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>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
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7343
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 July 14, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 4, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 4, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring

P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245325	A. BUILDING _____ B. WING _____	06/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOLEY NURSING CENTER	253 PINE STREET FOLEY, MN 56329

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 160 SS=E	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to convey resident funds deposited into trust accounts upon death, for 4 of 4 residents (R21, R43, R50, and R66), who expired and did not have their money returned to their family or personal estate within 30 days. Findings include: R21 expired on 4/11/15, at which time R21's personal fund account balance was $2937.63.	F 160	Tag 0160-483.10(c)96) Conveyance of personal funds upon death (long term care facilities) Upon death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's	6/12/15

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

Electronically Signed | 06/24/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245325	A. BUILDING _____ B. WING _____	06/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOLEY NURSING CENTER	253 PINE STREET FOLEY, MN 56329

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 160	Continued From page 1 As of 6/4/15, the funds were still being held by the facility and had not been conveyed to the family or R21's estate. R43 expired on 4/31/15, at which time R43's personal fund account balance was $5.26. As of 6/4/15, the funds were still being held by the facility and had not been conveyed to the family or R43's estate. R50 expired 4/22/15, at which time R50's personal funds account balance was $96.22. As of 6/4/15, the funds were still being held by the facility and had not been conveyed to the family or R50's estate. R66 expired on 3/24/15, at which time R66's personal funds account balance was $100.00. As of 6/4/15, the funds were still being held by the facility and had not been conveyed to the family or R66's estate. During interview on 6/4/15, at 8:15 a.m., administrative assistant (AA) stated she was responsible for overseeing the resident's personal funds accounts, and stated she was aware the residents personal funds were to be conveyed to the family or the residents estate within 30 days of death. AA stated the facility did not have a good system in place for retuning resident funds after death. A facility policy related to the conveyance of funds was requested and not provided.	F 160	estate. The Foley Nursing Center contacted Frandsen bank regarding the accounts reviewed during survey and these were resolved and currently have a zero balance/account closed per financial institution. The Foley Nursing Center has implemented a checklist for the release of personal funds for resident's upon their death. The responsible part will learn of a resident's death/discharge from the RN case manager or other designee and proceed to fill out the checklist form to close/release resident fund accounts. Once form is completed it will be turned into the billing office to be reviewed by hilling manager or designee to confirm funds have been released. This has been implemented on 6/12/2015.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility	F 282		6/30/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245325	A. BUILDING _____ B. WING _____	06/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOLEY NURSING CENTER	253 PINE STREET FOLEY, MN 56329

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 2 must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement the individual care plan as assessed for 1 of 3 residents (R7), reviewed for toileting. Findings include: R7's admission Minimum Data Set (MDS) dated 2/20/15, indicated R7 had moderate cognitive impairment, required extensive assist of one staff for transferring, mobility, and toileting, and had occasional urinary incontinence, and frequent bowel incontinence. R7's care plan dated 3/5/15, directed staff R7 required assistance of one staff for toileting and transferring . The care plan also indicated R7 was at risk for falls, and interventions to reduce falls included direction for staff to follow the toileting and mobility approaches as directed by the residents care plan. The facility undated Nursing Assistance Care Sheet indicated R7 was an assist of one for transfers and toileting. During observation on 6/2/15, at approximately 11:30 a.m., R7 was observed wheeling himself toward the bathroom in his room. R7 stated he needed to use the toilet, and did not need to call staff for assistance and would go to the bathroom on his own. Nursing assistant (NA)-A was alerted	F 282	Tag 0282 - 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (LONG TERM CARE FACILITIES) The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. The Foley Nursing Center reviewed care plan and group sheets pertaining to resident and found to be accurate. Provided re-education to the staff that work with the resident. The Foley Nursing Center created newly revised group sheets for staff to carry on their person with minimal but pertinent information to include transfers, toileting and ADL needs. These are updated by the restorative team member or designee. CNA staff will be re-educated on policy and procedure related to plan of care and group sheets at an all staff meeting on Tuesday June 30th. Random weekly audits will be conducted by the care manager or designee to spot check staff for their group sheets as well as knowledge or resident care needs x 4 weeks with any inaccurate information to	

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	245325	A. BUILDING _____ B. WING _____	06/04/2015

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FOLEY NURSING CENTER	253 PINE STREET FOLEY, MN 56329

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F 282	Continued From page 3 [by surveyor] R7 was going to use the bathroom on is own, and NA-A stated R7 was independent with transferring and toileting, and did not require staff assistance. NA-A was not observed providing R7 assistance with toileting as care planned. During a follow up interview on 6/4/15, at 10:56 a.m. NA-A stated she believed R7 was independent with transferring and toileting, and could use the bar in the bathroom to transfer himself to the toilet. During interview on 6/4/15, at 2:50 p.m. registered nurse (RN)-C stated R7 required assistance of one staff for toileting and transferring, and stated R7 should not be toileting himself without staff assistance as had been assessed and care planned. During interview on 6/4/15, at 3:17 p.m. director of nursing (DON) stated staff are expected to follow the care plan, and R7 was care planned to be assisted by one staff with transferring and toileting. A facility policy regarding following the care plan as assessed was requested but not provided.	F 282	include on the spot re-education.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		6/30/15

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F 309	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to assess and monitor an open skin area for 1 of 3 residents (R91) reviewed for non pressure related skin conditions. Findings include: R91's admission record dated 1/11/14, identified diagnoses including Alzheimer's disease and senile dementia. R91's quarterly Minimum Data Set (MDS) dated 3/20/15, indicated R91 had severe cognitive impairment and required extensive assistance from staff with all activities of daily living. During observation and interview on 6/1/15, at 6:40 p.m., R91 had a pea-sized open area with moist blood located on her right cheek next to her nose. R91 was not aware of the open area and could not explain what happened. During observation on 6/2/15, at 12:20 p.m. R91 was sitting in the dining room eating lunch. The pea-sized area on R91's right cheek was now a dark brown/red scab with reddened edges. During observation on 6/3/15, at 1:00 p.m. R91 was in the dining room and had just finished eating lunch, and the pea-sized scabbed area on her right cheek remained. During observation on 6/4/15, at 9:50 a.m. R91 was sitting in lounge area by the nurse's station, and the scabbed area remained on her right	F 309	Tag 0309 - 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING (LONG TERM CARE FACILITIES) Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Care Manager documented skin area on Thursday June 4th. Skin assessed and interventions put in place. Staff re-educated on reporting skin concerns immediately. The Foley Nursing Center currently has policy and procedure in place for skin concerns that are noted by staff. This was not followed by CNA staff and a re-education for CNA staff will occur on Tuesday June 30th. Care Manager or designee will perform a random audit on 2 baths per week x 4 weeks to ensure any skin concerns are noted and provide on the spot education to any staff that did not note or report such skin concerns. Any noted patterns or trends will be reported to the quality assurance committee for further	

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	245325	A. BUILDING _____ B. WING _____	06/04/2015

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F 309	Continued From page 5 cheek. A review of R91's medical record lacked any assessment or monitoring of the scabbed area. During interview on 6/4/15, at 10:09 a.m. registered nurse (RN)-C stated if a resident had any skin concerns, the assessment and monitoring should be documented in the residents medical record. RN-C stated she was not aware of R91's scabbed area on her face. RN-C reviewed R91's medical record and stated the residents record contained no information regarding the scabbed area on R91's face. During a follow up interview on 6/4/15, at 12:36 p.m., RN-C and licensed practical nurse (LPN)-D stated they spoke with a nursing assistant who told them she had assisted R91 with personal cares on Monday 6/1/15, and had noted the open area on R91's face at that time. RN-C stated she reeducated the nursing assistant regarding reporting skin concerns to the nurse, and RN-C stated she had just started an incident report regarding R91's scabbed area on her face. The facility's policy titled Pressure Ulcer Prevention-Skin Care Protocol dated 10/12, indicated, "The policy and procedures listed herein will apply to other skin conditions, such as skin tears, abrasions, cuts, venous, diabetic, stasis ulcers, etc... Nursing staff will continually examine each resident's skin condition for development of redness, discoloration, blisters and/or other abnormalities. If abnormal findings are observed, the Licensed staff will inform a RN within 24 hours...If a resident has an abnormal finding, the RN will assess the skin condition to determine what interventions and/or treatments	F 309	recommendations.	

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	245325	A. BUILDING _____ B. WING _____	06/04/2015

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F 309	Continued From page 6 are indicated..."	F 309		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		6/30/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245325	A. BUILDING _____ B. WING _____	06/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure used Fentanyl (narcotic analgesic) patches were disposed of according to facility policy to prevent potential diversion, for 4 of 4 residents (R10, R60, R72 and R38) reviewed with prescribed Fentanyl patches. Findings include: R10's admission record dated 2/19/08, indicated diagnosis including Alzheimer's disease and osteoarthrosis. R10's physician orders dated 1/8/15, indicated an order for Fentanyl patch 25 micrograms (mcg) to be applied topically (to the skin) every 72 hours. R60's diagnosis according to the admission record dated 10/21/14, included rehabilitation procedure, pressure ulcers, and generalized muscle weakness. R60's Medication Administration Record (MAR) dated 3/15, indicated directions for Fentanyl patch 25 mcg to be applied transdermally (to the skin) every 72 hours, starting on 3/13/15. R72's diagnosis as noted on the admission record, dated 12/16/14, included osteoporosis and pathologic fracture of vertebrae. R72's physician orders dated 5/7/15, indicated an order for Fentanyl patch 25 mcg to be applied transdermally every 72 hours. R38 Order Summary Report dated 3/5/15, included diagnoses of Paranoid Schizophrenia	F 431	Tag 0431 - 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS (LONG TERM CARE FACILITIES) The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. All residents that use fentanyl patches were reviewed to ensure a patch was located on them on Thursday June 4th. All residents did have a fentanyl patch placed with the correct dosing. Written logs were reviewed with the nurses on shift and requirements for proper documentation. The Foley Nursing Center has policy and procedure in place that outlines proper fentanyl patch destruction. Facility staff did not follow this policy. Nursing personnel reviewed and signed off acknowledgement of the policy and procedure between 6/9-6/15. Changes to the EHR to include adding an additional signature line for second nurse. Staff will still continue to document on paper flow sheet until compliance is noted	

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F 431	Continued From page 8 and osteoporosis. R38's MAR for June 2015, indicated and order for Fentanyl patch 75 mcg to be applied transdermally every 72 hours. During medication storage review on 6/2/15, at 3:41 p.m., registered nurse (RN)-D stated the facility's policy and procedure for the removal and disposal of Fentanyl patches was for two licensed staff, or a licensed staff and a trained medication assistant (TMA), to witness the disposal of the used Fentanyl patch down the sewer, and both staff were to sign off the destruction of the used Fentanyl patch in the log book kept at the nurse's station. During review of the Medication Destruction/Inventory Record from 3/1/15- 6/3/15, indicated the following: R10's Fentanyl patch destruction log lacked signatures for destruction of the used Fentanyl patches for 3/8/15, 3/23/15, 3/26/15, 4/16/15,4/25/15, 5/10/15, and 5/28/15. R60's Fentanyl patch destruction log lacked signatures for destruction of the used Fentanyl patch for 3/19/15. R72's Fentanyl patch destruction log lacked signatures for destruction of the used Fentanyl patches for 5/8/15, 5/14/15, 5/20/15, 5/23/15, 5/26/15, and 5/29/15. R38's Fentanyl patch destruction log lacked signatures for destruction of the used Fentanyl patch for 3/6/15, 3/27/15, 3/30/15, 4/2/15, 4/20/15, 4/26/15, and 4/29/15.	F 431	with EHR documentation as evidence by weekly audits of fentanyl patch users without error in documentation noted x 4 weeks. Monthly reports to be reviewed by DON or designee after that time to ensure compliance. Any significant findings will be brought to QA for recommendations.	

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F 431	Continued From page 9 During interview on 6/4/15, at 2:11 p.m. director of nursing (DON) stated the Medication Destruction/Inventory Records lacked consistent documentation of two signatures when staff disposed of the used Fentanyl patches. DON stated she received the destruction logs at the end of each month, however, she stated she didn't look at dates to be sure all of the used Fentanyl patches were documented, nor did she review to ensure two staff were signing off the destruction according to facility policy. Review of the facility policy titled Fentanyl Patches Removal & Disposal dated 3/14, directed staff to dispose of used Fentanyl patches immediately after removal from the resident by folding the patch in half, wrapping it in toilet paper, and flushing it into the sewer system. After removal of the patch, two licensed nurses, or a nurse/TMA, document the disposal on Medication Destruction Inventory sheet.	F 431		

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	245325	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/02/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on une 2, 2015 . At the time of this survey, Foley Nursing Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 Existing Health Care. This facility was surveyed as two separate buildings. Foley Nursing Center is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1970 and was determined to be of Type II(222) construction. In 1976, an addition was added to the north that was determined to be of Type V(111). In 1994 additions were added to the west of Units 2 & 4, additions to the Kitchen and Dining Room that were determined to be of Type II(000) construction and a Chapel addition to west of Unit 2 which was determined to be Type V(111) construction. In 2008 two additions were added to the facility , the North wing determined to be of type II(111) construction and the PT/OT addition determined to be of type II(111). Because the original building and the additions were constructed meet the construction type allowed for existing and new buildings, the facility was surveyed as two building. The building is fully sprinklered throughout. The	K 000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245325	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/02/2015**

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K 000	Continued From page 1 facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 89 beds and had a census of 79 at the time of the survey.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245325	A. BUILDING **02 - 2008 ADDITIONS** B. WING _____	**06/02/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on June 2, 2015. At the time of this survey, Foley Nursing Center was found 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 New Health Care. Foley Nursing Center is a one story building with full basement. The building construction type has been determined to be Type II(111). This inspection only reflects the building that opened 9-04-08. It is properly separated from the original building constructed in 1971. The building is fully sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 89 beds and had a census of 79 at the time of the survey.	K 000		

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

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