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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KT3D

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00477

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245537**
2.STATE VENDOR OR MEDICAID NO.
(L2) **328542100**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/24/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **43** (L18)
13.Total Certified Beds **43** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A, 8** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	43			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Lyla Burkman, Unit Supervior — 02/07/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist 04/06/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/27/1989
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/25/2017
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5537

Minnewaska Community Health Services was not in substantial compliance with Federal participation requirements at the time of the December 8, 2016 standard survey. On January 24, 2017, a Post Certification Revisit (PCR) Based on the PCR, it has been determined that the facility achieved substantial compliance pursuant to the standard survey completed December 8, 2016, effective January 10, 2017.

Effective January 10, 2107, the facility is certified for 45 skilled nursing facility beds.

The facility's request for a continuing waiver involving the health deficiency cited under F458 at the time of the December 8, 2016 standard survey has been forwarded to the Region V Office of the Centers for Medicare and Medicaid Services (CMS) for their review and determination. Approval of the waiver has been recommended.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245537
February 10, 2017

Mr. Christopher Knoll, Administrator
Minnewaska Community Health Services
605 Main Street, P.O. Box 40
Starbuck, MN 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 January 10, 2017 the above facility is certified for or recommended for:

43 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 43 skilled nursing facility beds.

Your request for waiver of F458 has been recommended based on the submitted documentation. You will receive notification from CMS only if they do not concur with our recommendation.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare Medicaid Program.

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
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 7, 2017

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

RE: Project Number S5537028

Dear Mr.. Knoll:

On December 21, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 8, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On January 24, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 8, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 10, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 8, 2016, effective January 10, 2017 and therefore remedies outlined in our letter to you dated December 21, 2016, will not be imposed.

Your request for a continuing waiver involving the deficiency cited under F458 at the time of the December 8, 2016 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245537 Y1	A. Building B. Wing Y2	1/24/2017 Y3

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

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0156	Correction	ID Prefix	F0280	Correction	ID Prefix	F0282	Correction
Reg. #	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18)	Completed	Reg. #	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2)	Completed	Reg. #	483.21(b)(3)(ii)	Completed
LSC		01/10/2017	LSC		01/10/2017	LSC		01/10/2017
ID Prefix	F0312	Correction	ID Prefix	F0314	Correction	ID Prefix	F0431	Correction
Reg. #	483.24(a)(2)	Completed	Reg. #	483.25(b)(1)	Completed	Reg. #	483.45(b)(2)(3)(g)(h)	Completed
LSC		01/10/2017	LSC		01/10/2017	LSC		01/10/2017
ID Prefix	F0441	Correction	ID Prefix	F0465	Correction	ID Prefix		Correction
Reg. #	483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	483.90(h)(5)	Completed	Reg. #		Completed
LSC		01/10/2017	LSC		01/10/2017	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	LB/mm	02/07/2017	28035	01/24/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
12/8/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KT3D

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00477

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(L1) **245537**
2.STATE VENDOR OR MEDICAID NO.
(L2) **328542100**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/08/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **43** (L18)
13.Total Certified Beds **43** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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: **B, 8** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	43			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Denise Erickson, HFE NEII 01/03/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist ___ 01/24/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/27/1989
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

Effective June 15, 2016, eight beds, previously on layaway status, were relicensed and then a total of 30 beds were immediately transferred to CG Care Center, LLC. The 30 beds will be licensed and certified at CG Care Center LLC. The transfer of beds was accomplished in accordance with the terms of a cost neutral bed relocaton, as summarized in the letter dated February 2, 2016 to Mr. Daniel A. Lindh, President, Presbyterian Homes and Services from Susan Winkelmann, Assistant Director, Health Regulation Division, Minnesota Department of Health.

At the time of the December 8, 2016 recertification survey the facility was not in substantial compliance with Federal participation requirements. The facility has been given an opportunity to correct before remedies would be imposed. The most serious deficiency 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 are required.

The facility's request for a continuing waiver involving the health deficiency cited under F458 at the time of the December 8, 2016 standard survey has been forwarded to the Region V Office of the Centers for Medicare and Medicaid Services (CMS) for their review and determination. The facility's compliance is based on pending CMS approval of your request for waiver.

Refer to the providers letter of waiver request dated December 26, 2016, CMS 2567 for both health and life safety code, and plan of correction for health. Post Certification Revisit (PCR) to follow.

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 21, 2016

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

RE: Project Number S5537028

Dear Mr.. Knoll:

On December 8, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A

Email: Lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 17, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 8, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 8, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Sincerely,

Mark Meath

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245537	A. BUILDING _____ B. WING _____	12/08/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility'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 156 SS=D	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -	F 156		1/10/17

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

Electronically Signed | 12/28/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245537	A. BUILDING _____ B. WING _____	12/08/2016

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

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F 156	Continued From page 1 (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older	F 156		

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F 156	Continued From page 2	F 156		

Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)
[§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)]

(iii) Information regarding Medicare and Medicaid eligibility and coverage;
[§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)]

(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program;
[§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)]

(v) Contact information for the Medicaid Fraud Control Unit; and
[§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)]

(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(g)(5) The facility must post, in a form and manner accessible and understandable to

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F 156	Continued From page 3 residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident	F 156		

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F 156	Continued From page 4	F 156		

understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.

(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.

(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;

(g)(17) The facility must--

(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-

(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;

(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and

(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section.

(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not

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F 156	Continued From page 5 covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide documentation of a two-day notice of denial of Medicare benefits for 1 of 3 residents (R47) whose liability notices were	F 156	Resident R47 has since discharge from the facility. It is the policy of Minnewaska Lutheran Home that all residents will be provided	

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F 156	Continued From page 6 reviewed. Findings include: R47's discharge Minimum Data Set (MDS) dated 11/11/16, indicated R47 received skilled therapy 10/24/16, through 11/10/16. The medical record lacked a 2-day notice of discharge from Medicare A. On 12/8/16, at 10:16 a.m. the MDS nurse verified R47 had received medicare benefits during her stay at the facility. The MDS Nurse verified R47 did not have a notification of denial form in her file, nor was one found elsewhere. On 12/8/16, at 12:26 p.m. the director of nursing (DON) verified R47 did not receive a medicare denial letter as required and should have. A requested facility policy was not provided.	F 156	with a proper liability and appeal rights notice in a timely manner prior to termination of Medicare skilled services. The Case Manager RN's have been educated on the requirements to provide proper liability and appeal rights notice in a timely manner prior to termination of Medicare. Monitoring to ensure compliance will be conducted by the Director of Nursing or designee through monthly audits. Results of the audits will be presented at QA in March, 2017 for review. Correction date: 1/10/2017	
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type,	F 280		1/10/17

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F 280	Continued From page 7 amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 280		

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F 280	Continued From page 8 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately revise the care plan to include the use of a pressure reducing boot for 1 of 3 residents (R43) reviewed for pressure ulcers and had a physician order directing the scheduled use of a pressure reducing protection device. Findings include: R43's computerized physician order dated 11/30/16, indicated R43 was to wear a pressure reducing boot to the left foot during daytime	F 280	The Care Plan for resident R43 has been reviewed to ensure that it continues to accurately reflect the resident's current status and current physician's orders. The Care Plans for all residents determined to be at risk for skin breakdown will be reviewed to ensure that their Care Plans accurately reflect the resident's current status and accurate physician's orders. On admission, Significant Change in resident status, and as residents come due for their next MDS (Minimum Data	

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F 280	Continued From page 9 hours. R43's care plan updated on 11/30/16, indicated R43 had severe cognitive impairment and required extensive assistance with ADLs. The care plan also indicated R43 was at risk for developing pressure ulcers and on 10/21/16, had developed a bluish/purple, 4.5 centimeters (cm) x 2.5 cm fluid filled blister on her left inner heel. The care plan directed staff to anticipate all of R43's needs and to follow facility wound protocol. The care plan further identified R43's physician ordered a pressure reducing boot and indicated the boot was to be worn at night only. R43's Treatment record for December 2016, indicated on 11/24/16, a pressure reducing boot was to be worn during night time hours. However, R43's physician order directed the use during the day time hours. On 2/07/16, at 11:38 a.m. R43 was observed seated in her wheelchair, in her room, in front of her TV. R43 had sheep skin which covered the left arm of her wheelchair and a black foam cushion under her bottom in the seat of her wheelchair. R43 wore gray, no-tie shoes with a low, half back across her left heel. R43's left heel was off the back of the footrest and she was not wearing a pressure reducing boot on her left foot. A pressure reducing boot was not observed in her room. -At 12:40 p.m. following lunch in the dining room, nursing assistant (NA)-F wheeled R43 into her room in front of TV. R43's left foot was off the foot rest, and rested on the floor. No boot was in place.	F 280	Set) assessment, resident's care plans will be reviewed to ensure the care plan continues to accurately reflect the resident's status and current physician's orders. By January 10, 2017, licensed nursing staff will attend an in-service. The Director of Nursing or designee will conduct the in-service. The in-service will cover: " A review of the regulations, " Review of the statement of deficiencies, " Review of the plan of correction, " Care Plan development, " Revision and updating of care plans as needed. The Director of nursing or designee will conduct audits weekly for a month and then monthly through the quarter. Results of audits will be presented to QA in March 2017 for review. Correction date: 1/10/2017	

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F 280	Continued From page 10	F 280		

-At 1:08 p.m. R43 was assisted into bed. R43 wore black socks, and was not wearing a pressure reducing boot on her left foot, and pressure reducing boots were not observed in her room. R43 remain in bed without the boot on until 2:40 when staff assisted her up.

-At 2:40 p.m. R43 was seated in her wheelchair in the dining room having coffee with spouse. R43 was not wearing her pressure reducing boot to her left foot, and wore her gray half-back shoes.

-3:29 p.m. R43 was seated in her wheelchair in the day room with spouse and was not wearing her pressure reducing boot to her left foot, and wore her gray half-back shoes.

On 12/7/16, at 2:16 p.m. NA-E stated R43 required extensive assistance with all activities of daily living (ADLs) and could not communicate. She stated she was not sure what shoes R43 wore, however had worn a protective boot at night and her heels were floated when she was in bed.

On 12/7/16, at 2:20 p.m. NA-D stated she thought R43 wore a boot on her left foot at night and not during the day.

On 12/7/16, at 2:26 p.m. Licensed practical nurse (LPN)-A stated R43 should wear a pillow boot whenever she was in bed. At 2:40 p.m. LPN-A stated she just learned R43 was to wear the pillow boots during the night, and not during the day. She stated she understood the staff's confusion with R43's pressure boot schedule

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F 280	Continued From page 11 because the order for it was not added to R43's care plan correctly. She stated on 11/30/16, LPN-C entered the order for R43's boots to be worn during the day, and on the same day, UM-B changed it to read R43 was to wear the pressure boot at night. On 12/8/16, at 12:36 p.m. the director of nurses (DON) confirmed R43's physician order to wear the boot during the daytime hours and verified R43's care plan had been changed to direct staff to apply the pressure reducing boot at night only. The DON stated she expected the care plan to be revised to reflect the accurate physicians order. Review of the facility policy, Care Plans-Comprehensive dated 10/22/16, identified care plans would be revised as resident condition dictated.	F 280		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) 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 provide turning and repositioning assistance as directed by the individualized care plan for 2 of 3 residents (R40,	F 282	The care plans of residents R40, R18, and R13 have been reviewed to ensure that the Care Plan continue to accurately reflect the resident's current status.	1/10/17

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F 282	Continued From page 12 R13) who required assistance with repositioning. In addition, the facility failed to provide grooming assistance for 1 of 1 resident (R18) who required staff assistance for the removal of facial hair. Findings include: R40 was not repositioned every two hours as directed by the care plan. R40's care plan updated 11/16/16, indicated R40 was at risk for skin breakdown due to chronic wound near rectum, end stage metastatic cancer, protruding colostomy, pain and peri-rectal infection and directed staff to encourage repositioning every two hours and as needed. R40's hospice care plan dated 10/25/16, indicated R40 had an open area on the right buttocks due to an abscess and directed staff to provide routine turning and repositioning. The A/B wing Turning and Repositioning worksheet dated 12/7/16, revealed R40 was last repositioned at 4:30 p.m. and indicated all residents were to be repositioned a minimum of every two hours, which included R40. On 12/07/16, from 5:25 p.m. to 7:35 p.m., continuous observations of R40 revealed the following: -At 5:25 p.m. R40 was observed lying in bed, on his left side. An air pressure mattress overlay was in place on R40's bed. R40 remained in bed, on left side without repositioning assistance until 7:35 p.m. at which time the director of nursing (DON) was notified. -At 7:35 p.m., the DON was notified R40 had remained lying in bed for an observed two hours	F 282	All residents who require assistance for grooming and who are at risk for pressure ulcer development or who currently have pressure ulcers have had their care plan reviewed for appropriate pressure ulcer interventions and for providing grooming assistance, with revisions if indicated. The Nursing Assistant's T&R sheets have been revised and updated if indicated to ensure that the necessary care interventions, including pressure ulcer interventions and assistance with grooming interventions are communicated to the nursing assistants. By January 10, 2017, nursing staff will be educated regarding care plans, including pressure ulcer interventions and grooming assistance, the communication system between staff, and expectations to follow the care plan and care guides provided. The Director of Nursing or designee will conduct daily audits on all shifts for one week; then daily audits alternating shifts for one week; then three times per week alternating shift through the quarter ending February 28th, 2017. Results of audits will be presented to QA in March, 2017 for review. Correction date: 1/10/2017	

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and 10 minutes without repositioning assistance and the Turning and Repositioning worksheet indicated R40 had last been repositioned at 4:30 p.m. At that time the DON confirmed R40 was at risk for skin breakdown and required assistance from staff with repositioning every two hours. The DON and nursing assistant (NA)-I proceeded to turn/reposition R40. R40 was noted to have approximately 3-4 inches of moderate amount of grey drainage from the rectal abscess on the brief. R40's buttocks had deep, light pink creases with moisture surrounding the peri-rectal area. The DON provided incontinent cares and repositioned R40 off of the left side. R40 was not repositioned for three hours and five minutes.

On 12/07/2016, at 5:20 p.m. NA-A stated R40 required assistance of repositioning every one hour.

On 12/7/16 at 7:47 p.m. the DON verified R40 required repositioning assistance every two hours and as needed. The DON confirmed R40 went three hours and five minutes without repositioning assistance and stated it was stated it was her expectation R40 would be repositioned every two hours, as directed.
R13 was not repositioned every two hours as directed by the care plan.

R13's care plan dated 11/1/16, indicated R13 was at risk for pressure ulcers and required encouragement to reposition every two hours and as needed.

During continual observation on 12/07/16, from 11:34 a.m. to 2:59 p.m. (3 hours and 29 minutes) R13 was observed seated in a wheelchair without repositioning assistance.

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-At 11:34 a.m. R13 was observed seated in her wheel chair in the chapel.
-At 11:42 a.m. R13 began to propel herself from the chapel when NA-D assisted to propel her to a table in the assisted dining room. R13 remained seated in the wheelchair throughout the meal time until 12:37 p.m. at which time NA-C wheeled R13 to her room. NA-C handed R13 a newspaper and left the room.
-At 12:53 p.m. remained seated in the wheelchair, in her room and remained seated until 1:13 p.m. at which time R13 propelled self out of her room, across the hall way and into another resident's room. An activity aid intervened and propelled R13 back to her room. The activity aid offered to read the newspaper to R13, but was declined.
-At 1:40 p.m. NA-G stepped in to the doorway of R13's room, turned and continued down the hall. R13 remained seated in the wheelchair, in her room until 2:13 p.m. at which time LPN-D entered R13's room and offered to take R13 to activities. R13 accepted and LPN-D wheeled R13 to the main dining room.
At 2:19 p.m. R13 remained seated in the wheelchair at a dining room table and had remained there until 2:33 p.m.
-At 2:46 p.m. R13 was in the chapel for an activity. R13 remained seated in the wheelchair without repositioning assistance.

On 12/7/16 at 2:04 p.m. NA-G stated the last time R13 was assisted out of the wheelchair was at 10:00 a.m. when she was assisted to the bathroom and had not been repositioned since that time. NA-G confirmed unawareness of R13's need to be turned and repositioned and stated R13 did not need to be repositioned every two hours. NA-G verified R13 had not been assisted to toilet or reposition for greater than four hours.

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F 282	Continued From page 15 On 12/7/16, at 2:51 p.m. the nurse manager (NM)-A confirmed R13 was to be repositioned every two hours. -At 2:59 p.m. NM-A assisted R13 into the bathroom. R13's bottom was noted to have wrinkles and creases and the skin between her buttocks and inner thighs were a darker pink in color. On 12/07/2016, at 5:16 p.m. LPN-D verified the nursing assistant care sheet directed staff to reposition R13 every two hours. On 12/07/2016, at 7:48 p.m. the DON stated she had expected staff to follow R13's care plan and reposition R13 every two hours, as directed R18 was not provided with facial hair removal as directed by the care plan. R18's care plan dated 10/27/16, indicated R18 required extensive assist of two staff for grooming and directed staff to report any changes in grooming needs/abilities. On 12/6/16, at 9:16 a.m. R18 was observed seated a wheelchair, in her room. R18 was noted to have several long, white facial hairs in the center of her chin and next to the right side of her lips. When R18 was asked if the long facial hair bothered her, she replied, "yes." On 12/6/16, at 2:36 p.m. R18 was observed in bed and continued to have the long facial hair which was approximately one inch in length.	F 282		

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F 282	Continued From page 16 On 12/7/16, at 2:23 p.m. R18 was again noted to have long facial hair. During review R18's progress notes, R18 was identified to have her shower on Mondays of each week. On 12/7/16, at 1:56 p.m. NA-C stated resident shaving was completed for all residents on a daily basis, by the nursing assistants and if any facial hair was noticed on bathing day, the bath aid would remove it. On 12/7/16, at 2:01 p.m. LPN-A confirmed R18 had long, white facial hair on her chin and next to her lip and verified she was totally dependent on staff for grooming needs which included shaving. LPN-A stated R18's shaver had been missing for the past month and family was requested to purchase another one as the facility did not provide razors for residents. On 12/7/16, at 2:15 p.m. NA-D stated staff tried to shave R18 1-2 times per week when providing morning cares. However, NA-D stated she had not offered nor provided shaving assistance for R18 when she assisted her up on 12/7/16. NA-D confirmed R18 currently did have a functioning razor, and pulled the razor out of R18's top drawer. NA-D confirmed R18 had multiple long, white facial hairs on the chin and next to the lip which needed removing. On 12/7/16, at 2:51 p.m., family member (FM)-A reported R18 has always had a functioning razor in her room because she bought it for her. FM-A stated she just went into R18's room and shaved her face, and confirmed the facial hair was long and no female would want those hairs on their face.	F 282		

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F 282	Continued From page 17 On 12/7/16, at 5:49 p.m. the DON stated she expected staff to provide grooming assistance as directed by the care plan. Review of the facility policy titled Care Plans-Comprehensive revised 10/22/16 revealed daily care and documentation must be consistent with the resident's care plan.	F 282		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide grooming services related to the removal of facial hair for 1 of 1 resident (R18) observed to have long facial hair which was not removed by staff. Findings include: R18's annual Minimum Data Set (MDS) dated 10/21/16, indicated R18 had moderate impaired cognition and required extensive assist of two staff for completing personal hygiene including shaving. R18's Activities of Daily Living Care Area Assessment (CAA) dated 10/28/16, indicated R18 required total to extensive assistance of two staff for activities of daily living due to left sided	F 312	The Plan of Care for resident R18 was reviewed to ensure that the care Plan continues to accurately reflect the resident's current status and updated if needed. All current and future residents requiring assistance with grooming services have been reviewed and will be provided assistance as specified per their care plans. The nursing assistance T&R sheets have been reviewed and updated if indicated to ensure that the necessary care interventions including personal needs and grooming services are communicated to the nursing assistants. By January 10, 2017, nursing staff will be educated regarding following resident's care plans, including providing assistance to the residents who are unable to carry out activities of daily living independently.	1/10/17

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F 312	Continued From page 18 paralysis from a stroke and a traumatic brain injury (TBI). R18's care plan dated 10/27/16, indicated R18 required extensive assist of two staff for grooming and directed staff to report any changes in grooming needs/abilities. On 12/6/16, at 9:16 a.m. R18 was observed in her room, seated in a wheelchair. R18 was noted to have several long, white facial hairs in the center of her chin and next to the right side of her lips. When R18 was asked if the long facial hair bothered her, she replied, "yes." On 12/6/16, at 2:36 p.m. R18 was observed in bed and continued to have the long facial hair which was approximately one inch in length. On 12/7/16, at 2:23 p.m. R18 was again noted to have long facial hair. During review R18's progress notes, R18 was identified to have her shower on Mondays of each week. On 12/7/16, at 1:56 p.m. nursing assistant (NA)-C stated shaving was completed for all residents on a daily basis by the nursing assistants assigned to provide care to the resident. NA-C stated if any facial hair was noticed on bath day, she would remove it. On 12/7/16, at 2:01 p.m. licensed practical nurse (LPN)-A confirmed R18 was totally dependent on staff for grooming, including shaving and stated R18's shaver had been missing for the past month. LPN-A stated R18's family was requested to purchase another one because the facility did not provide razors for the residents. LPN-A confirmed R18 had long, white facial hair on her	F 312	The Director of Nursing or designee will conduct daily audits on all shifts for one week; then daily audits alternating shifts for one week; then three times per week alternating shift through the quarter ending February 28th, 2017. Results of audits will be presented to QA in March, 2017 for review. Results of audits will be presented to QA in March 2017 for review. Correction date: 1/10/2017	

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F 312	Continued From page 19 chin and next to her lip which needed to be removed. On 12/7/16, at 2:15 p.m. NA-D confirmed R18 needed extensive assistance from staff for shaving and stated staff tried to shave R18 1-2 times per week. NA-D stated staff shaved the residents when they provided morning cares. NA-D verified she had assisted R18 with morning cares on 12/7/16, and had not offered nor provided shaving cares and had not attempted to shave R18 throughout the day. NA-D stated R18 currently did have a functioning razor and proceeded to pull the razor out of R18's top drawer. NA-D confirmed R18 had multiple long, white facial hairs on the chin and next to the lip which needed to be removed. On 12/7/16, at 2:51 p.m. family member (FM)-A stated R18 had always had a functioning razor in her room because she bought it for her. FM-A stated she had just went into R18's room and shaved her face, and confirmed the facial hair was long and no female would want those hairs on their face. On 12/7/16, at 5:49 p.m. the director of nursing (DON) verified R18 was depended on staff for grooming needs which included shaving and stated she expected staff to provide shaving needs with morning cares. A facility policy related to grooming was requested, but not provided.	F 312		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity -	F 314		1/10/17

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F 314	Continued From page 20 (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow a physician prescribed order for the use of a pressure reducing boot and/or provide turning and repositioning assistance in order to heal and/or prevent a pressure related ulcer and/or the worsening of a current pressure ulcer for 2 of 3 residents (R43, R13, R40) reviewed who were at risk for pressure ulcers and/or the worsening of a pressure ulcer and observed not to be wearing the pressure reducing boot as prescribed and/or turned and repositioned timely, as directed by the individualized care plan. Findings include: R43's pressure reducing boot was not provided as prescribed by the physician. R43's significant change Minimum Data Set (MDS) dated 10/17/16, indicated R43 had severe	F 314	The care plans for residents R43, R13, and R40 have been reviewed in that area of pressure ulcer treatment and prevention with revisions made if indicated. Other residents who have been assessed to be at risk for pressure ulcer development per use of Braden Scale, have had their care plans reviewed regarding pressure ulcer treatment and/or prevention with changes made as indicated. The nursing assistant T&R sheets have been reviewed and updated to ensure that necessary care interventions; including pressure ulcer treatment and preventions are communicated to the nursing assistants. By January 10, 2017, nursing staff will be educated regarding pressure ulcer treatment and prevention and expectations to follow the care plan and	

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F 314	Continued From page 21 cognitive impairment, required extensive assistance with all activities of daily living (ADLs) and had diagnoses which included dementia, diabetes, and aphasia (non-verbal). The MDS further identified R43 was at risk for pressure ulcers, had no current pressure ulcers and had no pressure ulcer prevention interventions in place. R43's computerized physician order dated 11/30/16, indicated R43 was to wear a pressure reducing boot to the left foot during daytime hours. R43's care plan dated 11/30/16, indicated R43 had severe cognitive impairment and required extensive assistance with ADLs. The care plan indicated R43 was at risk for developing pressure ulcers and on 10/21/16, had developed a bluish/purple, 4.5 centimeters (cm) x 2.5 cm fluid filled blister on her left inner heel. The care plan directed staff to anticipate all of R43's needs and to follow the facility wound protocol. The care plan indicated R43's physician had ordered a pressure reducing boot which was to be worn at night only. However, R43 ' s physician had ordered the boot to be worn during daytime hours. R43's Treatment Record for December 2016, indicated on 11/24/16, a pressure reducing boot was to be worn during night time hours. However, R43's physician order directed the use during the day time hours. Review of R43 ' s Physician communication forms revealed the following pressure related wounds: -10/21/16, R43 had a 4.5 cm x 2.5 cm blister on	F 314	care guides (T&R Sheet). Also, the expectation that all staff will follow physician orders for use of pressure ulcer reduction/prevention and provide turning and repositioning assistance in order to heal or prevent the development of pressure related ulcers. The Director of Nursing or designee will conduct daily audits on all shifts for one week; then daily audits alternating shifts for one week; then three times per week alternating shift through the quarter ending February 28th, 2017. Results of audits will be presented to QA in March, 2017 for review. Results of audits will be presented to QA in March 2017 for review. Correction date: 1/10/2017	

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left inner heel. Blister was bluish/purple and appeared fluid filled. The center of blister appears darker. Physicians response was to continue current cover left metatarsal.
-11/21/16, 4.0 cm X 2.5 cm left heel deep blue/purple tissue from wheelchair pedal has not resolved with betadine swabbing. Physician response was to continue to pad and protect.

R43's Braden Scale (assessment for pressure ulcer risk) dated 10/19/16, indicated R43 was at risk for developing pressure ulcers, had very limited ability to respond to pressure or discomfort, and was very limited in her ability to change or correct body position. The assessment also indicated R43 had a pressure reducing device in her chair, no referrals were needed and staff were to continue with current care plan.

R43's Activities of Daily Living Care Area Assessment (CAA) dated 10/24/16, indicated R43 had progressive Alzheimer's disease and required extensive assistance with ADLs. The CAA further indicated R43 was at risk for developing pressure ulcers, staff were to monitor R43's skin daily and notify the physician with any significant changes, staff were to follow the facility ' s wound protocol and to continue with the current care plan. The CAA failed to address R43's blister which developed in the facility on 10/21/16.

On 2/07/16, at 11:38 a.m. R43 was observed in her room, seated in the wheelchair. R43 had sheep skin which covered the left arm of her wheelchair, a black foam cushion on the seat of the wheelchair, had gray, no-tie shoes on with a low, half back across her left heel and was not wearing a pressure reducing boot on her left foot. R43's left heel was off the back of the footrest. A

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pressure reducing boot was not observed in her room.
-At 11:59 a.m. nursing assistant (NA-D) entered R43's room and informed R43 it was time for lunch and proceeded to remove the call light from R43's hands and wheel her out of her room into hallway.
-At 12:01 p.m. R43 was seated in her wheelchair in the dining room at a table. R43 was having a hard time keeping her eyes open.
-At 12:07 p.m. NA-F physically assisted R43 with her with meal. R43 dozed on and off during feeding.
-At 12:40 p.m. following completion of the meal, NA-F wheeled R43 into her room and positioned her in front of TV. R43's left foot was off the foot rest, and rested on the floor.
-At 12:59 p.m. NA-D and NA-E entered R43's room with a mechanical lift and closed the door.
-At 1:08 p.m. R43 was observed in bed on her back with her left heel on top of a flattened pillow. R43 wore black socks and was not wearing a pressure reducing boot on her left foot. A pressure reducing boot were not observed in her room.
-At 1:36 p.m. and at 2:02 p.m. R43 was observed to remain in bed, on her back with her left heel under a flattened pillow. The sock remained on and a pressure reducing boot was not in place nor in her room.
-At 2:26 p.m. R43 remained positioned in bed on her back with the left heel under a flattened pillow.
-At 2:40 p.m. R43 was observed in the dining room, seated in her wheelchair. R43 was not wearing a pressure reducing boot to her left foot, and wore her gray half-back shoes.
-At 3:29 p.m. R43 was seated in her wheelchair in the day room with spouse and was not wearing

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her pressure reducing boot to her left foot, and wore her gray half-back shoes.
-At 3:44 p.m. R43 was in her room with Unit Manager (UM-A) and spouse. R43 was not wearing a pressure reducing boot to her left foot. R43's left inner heel was observed with Um-A which revealed the following heel wounds:
-0.5 cm x 0.4 cm reddened area which was soft and broken down
-0.3 cm x 0.2 cm reddened area which was soft and open
-0.2 cm hard blackened oval area

On 12/07/16, at 2:16 p.m. NA-E stated R43 required extensive assistance with all ADLs and could not communicate. NA-E stated she was not sure what shoes R43 wore but knew R43 wore a protective boot at night and her heels were to be floated when she was in bed.

On 12/07/16, at 2:20 p.m. NA-D stated R43 required extensive assistance with ADLs. She stated R43 had a black, hard blister the size of a silver dollar on her left heel. She stated she felt R43 developed the blister to her left heel because staff had not kept her feet elevated enough and was not repositioned all the time. NA-D stated staff tried to reposition R43 every two hours and also elevate her feet with a pillow or two and thought R43 wore a boot on her left foot at night and not during the day. NA-D stated R43 was not to wear socks when she had the boot on.

On 12/07/16, at 2:26 p.m. licensed practical nurse (LPN)-A stated R43 required total care from staff, had a huge blood blister on her left heel which she thought was a pressure related ulcer. She stated staff thought the blister was caused from her wheelchair foot pedals and/or someone had

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not put her shoes on all the way which caused friction. LPN-A stated R43's heel was to be protected by making sure staff were putting her shoes on correctly, because R43's shoes did not have not full backs on them, and confirmed R43 had on the same shoes as when she developed the pressure ulcer to her left heel. LPN-A also stated staff were to float 43's heels and apply a pillow boot when she was in bed. She stated R43 had an alternating air mattress and was repositioned and cleansed properly. LPN-A stated R43 should have had her boots on at this time and would go check to see if she had them on.

-At 2:40 p.m. LPN-A returned and stated she had learned R43 was to wear the pillow boots during the night, and not during the day. She stated she understood the confusion with R43's boot schedule because the order was not documented correctly on R43's care plan. LPN-A stated on 11/30/16, LPN-C had entered the order for R43's boots to be worn during the day, and on 11/30/16, UM-B changed the care plan to read R43 was to wear boots at night. LPN-A verified there were no progress notes associated with the physician order for R43's protective boot and stated " it was bizarre. " In addition, LPN-A stated R43's pressure reducing boot was applied originally applied on 10/21/16, but she could not find the original order for the boot dated 10/21/16.

On 12/7/16, at 3:29 p.m. family member (FM)-B stated R43 had worn the protective boot every day until yesterday as her understood the scab had fallen off and R43 did not need the boot anymore. RM-B stated R43 had a dead blood blister the size of a quarter before Thanksgiving and R43 had worn the same shoes which had nothing to do with her developing the blister.

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FM-B stated he thought the blister was caused by the foot pedal guards on her wheelchair. FM-B stated the current pressure ulcer interventions for the blister were betadine swabs and wearing the boot.

On 12/8/16, at 12:36 p.m. the director of nurses (DON) stated once R43's blister was identified, they determined it was caused from pressure from her wheelchair foot pedal bars. She stated they had removed the bars and applied a protective boot to R43 ' s left foot which she wore all day and night. The DON stated her and UM-B had discussed R43 wearing the boot during the day and both felt it was a dignity issue so on 11/30/16, UM-B had changed the schedule of the boot to night time use only. The DON stated she expected the physician order to be accurate and followed as written and for the order to match the care plan. She stated she expected the care plan to be accurately revised to reflect the actual physicians order.

On 12/08/16, at 1:50 p.m. The DON confirmed R43 was at risk for developing pressure ulcers and verified R43 ' s medical record lacked any progress notes related to the use of the protective boot and she was unable to find the original physician's order for the boot.

R40 was at risk for pressure related ulcers and was not provided timely repositioning, as directed.

R40's admission MDS dated 10/31/16, indicated R40 was cognitively intact and had diagnoses which included malignant neoplasm of colon and liver, rectal abscess and pain. The MDS

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indicated R40 was at risk for pressure ulcers and required supervision, cueing and oversight along with one staff assistance for bed mobility and transferring. The MDS did not identify any pressure ulcer prevention interventions in place.

R40's Pressure Ulcer Care Area Assessment (CAA) dated 11/10/16, indicated R40 had an open abscess near his rectum with wound drainage which put him at risk for skin breakdown.

The Minnewaska Lutheran Home Admission Skin Condition form dated 10/1/16, revealed R40 had an open area on right buttocks. The form did not identify any pressure ulcer interventions had been put into place.

R40's Braden Scale dated 10/31/16, indicated R40 was at risk of skin breakdown.

R40's care plan dated 11/16/16, indicated R40 was at risk for skin breakdown due to chronic wound near rectum that had purulent drainage, end stage metastatic cancer, protruding colostomy, pain and peri-rectal infection. R40's care plan directed staff to encourage repositioning every two hours and as needed.

R40's hospice care plan dated 10/25/16, indicated R40 had an open area on the right buttocks due to an abscess. Various interventions had been put in place which included routine turning and repositioning.

The A/B wing Turning and Repositioning worksheet dated 12/7/16, revealed R40 had been last repositioned at 4:30 p.m. The form revealed all the residents were to be repositioned a minimum of every two hours, which included R40.

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F 314	Continued From page 28 On 12/7/16, at 5:25 p.m. R40 was observed in bed lying on his left side. An air mattress overlay was observed on his bed. Continuous observation of R40 continued until 7:35 p.m. in which R40 remained in bed on his left side without repositioning. -At 7:35 p.m. the DON was notified R40 had remained lying in bed for an observed two hours and 10 minutes. The DON confirmed R40 was at risk for skin breakdown and required assistance from staff to turn and reposition every two hours. The DON and NA-I proceeded to assist R40 with incontinent cares and repositioning. When R40 ' s incontinent brief was removed, R40 ' s rectal wound was noted to have approximately 3-4 inch in diameter of gray drainage on the brief. R40's buttocks had deep, light pink creases with moistness surrounding the peri-rectal area. The DON and NA-I proceeded to complete perineal cares and repositioned R40 off of his left side. R40 had remained in the same position for a total of 3 hours and 5 minutes. According to the A/B wing Turning and Repositioning worksheet dated 12/7/16, R40 was not turned and repositioned for three hours and five minutes. On 12/7/2016, at 5:20 p.m. NA-A stated R40 required assistance with repositioning every one hour. On 12/7/16 at 7:47 p.m. the DON confirmed the aforementioned observations and verified R40 required turning and repositioning assistance every two hours, and as needed. The DON verified according to the A/B wing Turning and Repositioning worksheet, R40 was last repositioned at 4:30 p.m. and stated her expectation was for staff to reposition R40 every	F 314		

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F 314	Continued From page 29 two hours, as directed. On 12/8/16 at 8:49 a.m. during phone interview with R40's hospice registered nurse (RN)-D verified R40 was at high risk for skin breakdown and stated R40 required good perineal cares and would expect R40 to be repositioned at least every two hours. R13 was identified at risk for pressure ulcers and every two hour turning and repositioning was not provided as directed by the care plan. R13's Physician Order Report dated 10/19/16, identified R13's diagnoses included Parkinson's disease, dementia and peripheral vascular disease, (a blood circulation disorder). R13's quarterly MDS dated 10/25/16, indicated R13 was at risk for pressure, required extensive assist of one staff for bed mobility and transfers and utilized a wheelchair cushion pressure reducing device. R13's Braden Scale for Predicting Pressure Sore Risk, dated 10/24/16, indicated R13's skin was occasionally moist, R13 spent most of each shift in bed or chair, had slightly limited mobility, ate adequately, and had a potential problem with friction and shear. The Braden indicated R13 was at risk for pressure sores, had a pressure reducing device for her chair and the current care plan interventions was to continue. R13's Tissue Tolerance Test dated 10/20/16, indicted R13 could tolerate two hours seated or laying in one position without change to skin condition.	F 314		

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R13's Activities of Daily Living Care Area Assessment dated 2/2/16, indicated R13 was at risk for skin break down and every two hour, and as needed, repositioning interventions were in place.

R13's care plan revised 11/1/16, indicated R13 was at risk for pressure ulcers and required encouragement to reposition every two hours and as needed.

During observation on 12/07/16, from 11:34 a.m. to 2:59 p.m. (3 hours and 29 minutes) R13 was observed seated in a wheelchair without having been repositioned.
-At 11:34 a.m. R13 was observed in the chapel, seated in her wheelchair.
-At 11:42 a.m. R13 began to propel herself in the wheelchair from the chapel when NA-D walked up behind R13's wheelchair and propelled her to a dining room table. R13 remained in the dining room, seated in the wheelchair until 12:37 p.m. at which time, NA-C wheeled R13 to her room, handed R13 a newspaper and exited the room.
-At 12:53 p.m. R13 was observed seated in her wheelchair, in her room.
-At 1:08 p.m. R13 remained in the wheelchair, asleep.
-At 1:10 p.m. R13 turned the wheel chair towards the window and sat quietly.
-At 1:13 p.m. R13 propelled herself out of the room, across the hall and into another resident's room. An activity aid intervened and wheeled R13 back to her room. The activity aid offered to read the newspaper to R13, but was declined.
-At 1:40 p.m. NA-G stepped into the doorway of R13's room, turned and continued down the hall.
-At 1:45 p.m. R13 remained seated in the wheelchair in her room. Two nursing assistants

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and the LPN and a student nurse were in the room next door with another resident.
-At 1:52 p.m. R13 remained seated in the wheelchair in her room.
-At 2:13 p.m. LPN-D entered R13's room and offered to assist R13 to activities. R13 accepted and LPN-D wheeled R13 to the main dining room. R13 was not offered repositioning assistance.
-At 2:19 p.m. R13 remained seated in the wheelchair at a dining room table with four other residents. R13 drank from a covered mug with a straw and ate a dessert.
-At 2:33 p.m. R13 remained at the table drinking from the covered mug.
At 2:46 p.m. R13 was in the chapel for an activity. She remained seated in the wheelchair.

On 12/7/16 at 2:04 p.m. NA-G stated nursing assistant staff used a book at the nurse station to write down what cares were provided for a resident and at what time. The form was titled A/B wing Turning and Repositioning Worksheet which was dated 12/7/16. NA-G stated the oncoming staff transferred the last times care was provided and documented for each resident on to a new form. NA-G confirmed night staff had written 4:00 a.m. for R13. However, NA-G stated she was unaware of what cares night staff had provided R13 at 4:00 a.m. and verified it could have been anything from toileting to visual checking on her. NA-G confirmed the following was also documented on the form by the day shift staff:
At 8:10 a.m. R13 was assisted up from bed.
At 10:00 a.m. R13 was assisted to the toilet.
At 10:30 R13 was observed at church.
At 1:00 p.m. checked.
NA-G verified R13 had not been repositioned for greater than four hours. NA-G was also unaware of R13 ' s turning and repositioning schedule and

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stated R13 was not to be repositioned every two hours or anything like that.

On 12/7/16, at 2:30 p.m. shift change was occurring at the A/B wing nurses station.

On 12/7/16, at 2:38 p.m. NA-H stated R13 was visually checked on every half hour R13 did not have a repositioning schedule but would be repositioned when toileted. NA-H verified she had not toileted R13 this afternoon and the Turing and Repositioning Worksheet identified R13 was last toileted at 10:00 a.m. which was four and a half hours earlier.

On 12/07/16, at p.m. 2:51 p.m. nurse manager (NM)-A verified R13 should be repositioned every two hours and expected staff to do so. NM-A reviewed the Turning and Repositioning form and verified there was no documentation of R13 having been repositioned or refusing repositioning. At 2:59 p.m. NM-A assisted R13 into the bathroom and assisted R13 to stand with the use of a gait belt and assistive bars bolted to the bathroom wall. R13's bottom was noted to have wrinkles and creases and the skin between her buttocks and inner thighs were dark pink in color. NM-A indicated she would direct staff to be diligent with repositioning R13 every two hours because of her recent decline and was no longer able to stand independently.

On 12/07/2016, at 5:16 p.m. LPN-D stated R13 had a recent decline in physical and mental ability, was at risk for pressure ulcers and required repositioning every two hours. LPN-D verified the nursing assistant care sheet directed staff to reposition R13 every two hours.

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F 314	Continued From page 33 On 12/07/2016, at 7:48 p.m. the DON stated she had expected staff to reposition R13 every two hours according to the tissue tolerance assessment and care plan. The facility Prevention of Pressure Ulcers policy reviewed 12/3/15, indicated pressure related ulcers were usually formed when a resident remained in the same position for an extended period of time causing increased pressure or a decrease of circulation (blood flow) to that area, which destroyed the tissues. Risk factors and preventive actions for a person in a chair included changing positions every two hours and use a foam, gel, or air cushion to relieve pressure. The facility Skin Care policy dated 12/3/16, indicated residents who had pressure sores would receive the recommended treatment and services to promote healing and prevent new sores from developing. The facility Turning a Resident on his/her Side policy reviewed 3/3/2000, indicated the purpose was to provide comfort to the resident, to prevent skin irritation and breakdown and to promote good body alignment. The facility Care Plans-Comprehensive policy revised 10/22/16, indicated daily care and documentation must be consistent with the resident's care plan.	F 314		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency	F 431		1/10/17

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drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals.
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.

(h) Storage of Drugs and Biologicals.
(1) 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

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F 431	Continued From page 35 have access to the keys. (2) 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly secure controlled substances while waiting for destruction for 1 of 1 resident (R39) who currently utilized Fentanyl patches. This practice had the potential to affect all 40 residents who resided in the facility. Findings include: On 12/8/16, at 9:43 a.m. during a random review of the A-B wing medication storage cart, a black bound narcotic (medications that have a high likelihood of abuse) medication log book was observed unsecured, on top of the cart. A used Fentanyl narcotic patch was observed tucked inside the front cover of the. At this time, registered nurse (RN)-A stated she had placed R39's used Fentanyl patch in the narcotic book on 12/8/16, at 6:30 a.m. after she had applied R39's new Fentanyl patch. RN-A stated she had placed the used patch in the narcotic book until a staff member was available to witness the destruction of it. RN-A confirmed the narcotic book and Fentanyl patch had been unsecured on top of the medication cart since that time. RN-A	F 431	All facility medication carts and medication rooms were immediately audited for proper medication storage, labeling, and record keeping. Storage of controlled substances was reviewed and small containers that fit into the locked box on the Med Cart were provided for holding narcotic patches once removed from the resident until a licensed staff member is available to witness destruction. The facility policy on Controlled Substances Containing Transdermal Delivery System was reviewed and is current. By January 10, 2017, licensed nursing staff and TMA's will attend an in-service which will address the use and storage of controlled substances. The Director of Nursing or designee will conduct audits weekly for one month then monthly through the quarter. Results of audits will be presented to QA in March, 2017. Correction date: 1/10/2017	

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stated the narcotic book did not fit into the double locked compartment inside the medication cart and the facility's current process of storing used Fentanyl patches was not the perfect system.

R39's individual narcotic record, page 91, indicated a new Fentanyl patch 75 micrograms (mcg) was applied on 12/8/16, at 6:30 a.m.

On 12/8/16, at 9:48 a.m. RN-A and RN-B were observed to dispose of the used Fentanyl patch into the sewer, both nurses signed R39's narcotic record.

On 12/8/16, at 10:30 a.m. the director of nursing (DON) stated the nurse tucked the used Fentanyl patch into the narcotic book for storage until a witness was available for destruction. The DON confirmed the narcotic book did not fit into the medication cart's double locked compartment and was placed unsecured on top of the medication cart which was the facility's usual practice for storage of used Fentanyl patches until destruction. The DON acknowledged controlled medication remained in the used Fentanyl patches.

The facility's Controlled Substances Containing Transdermal Delivery System (i.e.: fentanyl) policy dated 8/6/15, indicated all controlled substances must be stored in the medication cart in a locked container, separate from containers for any non-controlled medications or in the locked medication room in a locked cabinet. This container must remain locked at all times, except when it is accessed to obtain medications for residents. Used Fentanyl patches must be flushed down the hopper in the utility room and be witnessed by another nurse. Both nurses are

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F 431	Continued From page 37 required to sign off in the narcotic record.	F 431		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to:	F 441		1/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245537	A. BUILDING _____ B. WING _____	12/08/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 38 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate infection control measures were implemented for a communally used glucometer/blood glucose meter. This practice had the potential to effect all 6 residents (R3, R16, R20, R25, R35, R41) who required blood glucose monitoring on the A/B wings.	F 441	Licensed nursing staff and TMA's (trained medication aides) have received education on proper disinfection of glucometer machines after use. The facility policy on "Maintaining the Glucometer/Cleaning" was reviewed and is current. By January 10, 2017 licensed nursing staff and TMA's will attend an in-service	

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F 441	Continued From page 39 Findings include: On 12/07/2016, at 5:47 p.m. licensed practical nurse (LPN)-D was observed to cleanse her hands, gather supplies from the cart and donned gloves. Behind a curtain in a small storage area, LPN-D wiped R-16's finger with an alcohol wipe, air dried the finger and used a disposable lancet to prick R16's finger. LPN-D used the glucometer (a medical device used to measure sugar levels in blood) to check R-16 ' s blood sugar level. LPN-D returned to the medication cart, disposed of the disposable items and placed the glucometer on the top of the cart. -At 5:52 p.m. LPN-D placed a needle on the Humalog insulin pen and turned the dial to 22 units. LPN-D obtained an alcohol wipe and returned behind the curtain and administered R16's insulin. LPN-D returned to the medication cart, placed the insulin needle into the sharps container (container for used medical needles and equipment), disposed of the alcohol wipe and gloves. Without cleaning or disinfecting the glucometer, LPN-D picked it up from the top of the medication cart and placed it into the top drawer of the medication cart. -At 6:05 p.m. LPN-D obtained the same glucometer, meter strip, alcohol wipe and R41's Levemir insulin pen. LPN-D went behind the curtain in the hall with R41. LPN-D used hand sanitizer, donned gloves, placed the strip into the glucometer machine and grasped R41's left hand in order to obtain a blood sample. At this time the surveyor intervened. LPN-D did not proceed to check R41's blood sugar and returned to the medication cart with the glucometer.	F 441	which will address the procedure for disinfecting the glucometer in between use. The Director of Nursing or designee will conduct daily audits on all shifts for one week; then daily audits alternating shifts for one week; then three times per week alternating shift through the quarter ending February 28th, 2017. Results of audits will be presented to QA in March, 2017 for review. Results of audits will be presented to QA in March 2017 for review. Correction date: 1/10/2017	

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F 441	Continued From page 40 -At 6:08 p.m. LPN-D verified the intent to use the multi-use glucometer to check R41's blood sugar without disinfecting it after it had been used to check R16's blood sugar and verified this practice had the potential to spread infection. LPN-D stated the usual facility practice was to disinfect the communally used glucometer after each use. LPN-D verified all diabetic residents currently served by this medication cart had personal glucometers which were kept in their rooms, however, the communally used glucometer from the cart was used when the residents were away from their rooms. On 12/08/2016, at 12:21 p.m. the director of nursing (DON) verified a glucometer was available in the medication cart for residents who did not have a personal glucometer in their room. The DON stated she expected the multi-use glucometer machines be disinfected between resident use to prevent the spread of germs and bacteria and to follow basic infection control practices. The DON indicated all nursing staff were aware of the infection control practice. The facility policy titled Maintaining the Glucometer/Cleaning, revised 12/5/15, indicated it was policy to advise nursing staff to clean and disinfect blood glucose meters between each resident to avoid possible cross-contamination.	F 441		
F 458 SS=E	483.90(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT (d)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; This REQUIREMENT is not met as evidenced by:	F 458		1/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 458	Continued From page 41 Based on observation, interview and document review, the facility failed to ensure the 13 resident rooms on the A-wing had at least 100 square feet of useable floor space for 12 of 12 residents (R8, R12, R13, R14, R17, R20, R22, R24, R25, R27, R35, R39) who currently resided in those rooms. Findings include: During the tour of A-wing on 12/5/16, at 12:00 p.m. R8, R12, R13, R14, R17, R20, R22, R24, R25, R27, R35 and R39's rooms were observed to not have at least 100 square feet of useable floor space, as required. On 12/5/16, at 1:58 p.m. R17 was observed in bed. The room appeared neat and orderly. -At 2:28 p.m. R8 indicated she was pleased with her room and was able to have all the things she needed in her room, including her knitting supplies. -At 2:45 p.m. R39 reported no concerns with the small room size. -At 3:02 p.m. R13 was observed propelling herself in a wheelchair in her room. R13 was not observed to have difficulty moving about the room. -At 3:17 p.m. R20 indicated he liked his room. -At 3:36 p.m. R25 reported no concerns with the small room size. On 12/06/2016 08 a.m. R24 reported no concerns with the small room size. On all days of the survey R22 was unavailable to be interviewed due to her busy schedule. R12 also was not interviewed. All rooms appeared clean, orderly, and home like.	F 458	F458 Waiver requested: in rooms A-wing 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, and 36 are 95.68 to 96.07 square feet of usable space and do not meet the minimum requirements of at least 100 square feet of usable space. Formally complying bedrooms were reduced in areas to accommodate expanded toilet rooms. A previous similar waiver was requested. Waiver submitted on December 28, 2016.	

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F 458	Continued From page 42 On 12/08/2016, at 9:10 a.m. nursing assistant (NA)-F verified the rooms on A-wing were a little tight when assisting residents and even more so when a mechanical lift was needed. NA-F stated staff were able to manage all resident needs even though the area was small. On 12/08/2016 9:17 a.m. R12 refused interview. On 12/8/16, at 12:19 p.m. the director of nursing (DON) indicated she was aware of the A wing rooms not being the required square footage and stated she had not had any resident complaints regarding the small room size. On 12/8/16, at 1:04 p.m. R14 stated although the room was small, the benefits of a private room with its own bathroom and a nice view were worth having the smaller living space. R14 stated her daughter was happy with the room and had told R14 the room felt cozy. On 12/8/16, at 1:07 p.m. R27 reported she liked her room, had been offered to move to a larger room, however, had declined and stated "it is home." On 12/8/16, at 2:29 the administrator verified the resident rooms on the A-wing did have less than 100 square feet of usable space and the facility would apply for a waiver for this requirement. On 12/8/16, at 2:38 p.m. the facility environmental services director (ESD) stated the single rooms on the A-wing were less than the required 100 square feet of useable floor space, and the facility would be applying for a room wavier. The ESD stated there were no problems maintaining	F 458		

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F 458	Continued From page 43 cleaning and upkeep of the rooms.	F 458		
F 465 SS=E	483.90(h)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (h) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (h)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility to maintain resident bathrooms in a clean and sanitary manner for 15 of 30 resident bathrooms on the A and C wings (A26, A28, A30, A32, A34, C101, C103, C104, C106, C108, C109, C110, C111, C113, C116) observed to be in need of cleaning and repair. Findings include: During resident room observations on 12/5/15, the following was identified: -Room A26, the off-white bathroom tile floor was dirty and stained dark behind the toilet -Room A28, the off-white bathroom tile floor was dirty and stained dark behind the toilet	F 465	A whole facility environmental audit will be conducted on 01/03/2017 with the results of the findings and information reviewed by the Environmental Service Director, the Administrator, and the Director of Nursing. Each area will be prioritized and corrected in the order prioritized. When the housekeepers are in the resident rooms, they will note repairs that need to be completed on the work orders, located at the C-wing nurse's station. By January 10, 2017, as part of the nursing in-service as well as an in-service will be provided to the housekeepers to update on the procedures to follow when issues are noted within the environment, filling out "Repair Request Slips". The Environmental Service Director or designee will conduct semi-annual rounding to look for areas in need of	1/10/17

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F 465	Continued From page 44 -Room A30, the caulking around the white toilet base was dark brown, and the off-white floor tile behind the toilet was dirty and stained dark -Room A32, the off-white bathroom tile floor had built-up dirt in the corners -Room A34, the off-white bathroom tile floor was dirty and stained dark, and the bathroom sink had green lime scale build up on the unit and the handles -Room C101, the off-white bathroom tile floor was dirty, the bathroom door was scratched and damaged towards the bottom of the door, and the bathroom sink had green lime scale build up on the unit and the handles. -Room C103, the off-white bathroom tile floor was dirty, the bathroom door was scratched and damaged towards the bottom of the door, and the bathroom sink had green lime scale build up on the unit and the handles -Room C104, the off-white bathroom tile floor was stained and dirty, and the bathroom sink faucet had green lime scale build up on the unit and the handles. -Room C106, had a large rust stain on the off-white bathroom floor tile behind the toilet which measured approximately 4 inches x 4 inches, and the bathroom faucet had green lime scale build up on the unit and the handles. -Room C108, had a large rust stain to the off-white bathroom floor tile behind the toilet which measured approximately 4 inches x 4	F 465	environmental repairs. The results of the audit will be reviewed by the QA Committee in March, 2017 for review and further recommendations. Correction date: 1/10/2017	

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F 465	Continued From page 45	F 465		

inches, and the bathroom faucet had green lime scale build up on the unit and the handles.

-Room C109, the bathroom sink had built up green lime scale on the unit and the handles.

-Room C110, the bathroom sink had built-up green lime scale on the unit and the handles, the off-white bathroom floor tile was dirty and stained underneath the sink, on the sides of toilet, and behind the toilet.

-Room C111, had significant scrapes to the bathroom wall opposite of the toilet, and the bathroom sink had built-up green lime scale on the faucet and the handles, and the off-white bathroom floor tile was dark, and in poor condition.

-Room C113, the bathroom faucet had built-up green lime scale on the unit and on the handles.

-Room C116-1 and C116-2, the bathroom faucet had built up green lime scale on the unit and the handles.

On 12/08/16, at 9:10 a.m. Environmental Services Director (ESD) stated he was responsible for all facility maintenance, housekeeping and laundry services. He stated staff were to complete a repair request slip, and leave it at the C nurses station in the designated container. He stated they checked the container for slips at least daily. He stated when they removed the repair request slips from the C nurses station they prioritized and completed the repairs. He stated after they completed a repair they signed the slips, and stored them in a box on the tool shelf in the boiler room. He stated all

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F 465	Continued From page 46 staff were trained annually on how to complete the request slips for repairs. He confirmed he was not aware of the resident room concerns, and had not received any repair request slips for the identified concerns. He stated he was short a couple of staff, and they hadn't had time to maintain the resident rooms the way they should be. He stated there was no excuse for the resident bathrooms to look like they did. On 12/08/16, at 12:36 p.m. director of Nursing (DON) stated she was aware of the dirty resident bathrooms on A wing, and stated she just assumed resident bathrooms on the other wings were bad too. She stated she had mentioned the dirty bathrooms to the ESD in the past, and stated she expected the ESD to clean and maintain the resident rooms. She stated she felt resident rooms had not been maintained because the facility was short staffed in housekeeping and maintenance. Review of the facility policy, "Bathrooms" dated 7/21/09, identified bathrooms would be maintained in a clean and sanitary manner and shall be cleaned on a daily basis.	F 465		

Minnewaska Community Health Services
a community of services grounded in faith

December 26, 2016

Gail Anderson, Unit Supervisor
Minnesota Department of Health
1505 Pebble Lake Road #300
Fergus Falls, Minnesota 56537

Dear Ms. Anderson:

Please accept this letter as our request to ask for a Federal waiver for the deficiency cited during our standard state survey completed by the Minnesota Department of Health and Public Safety on December 5, 2016. The waiver request is in response to the following Federal Deficiency:

1. F 458 483.70 (d)(1)(ii) Bedrooms Measure at least 100 Sq. Feet for one bed, private bedrooms.

A waiver has been previously reviewed and approved at the Minnesota Department of Health.

A Wing rooms: 24,25,26,27,28,29,30,31,32,33,34,35 and 36

Residents: R8, R12, R13, R14, R17, R20, R22, R24, R25, R27, R35, R39

The facility recognizes that the square footage in the A wing for the private one bed rooms noted are between 95.68 to 96.07 square feet and will work to address the comments/concerns noted by residents in the deficiency.

A previous remodeling and expansion of the toileting rooms on the "A" wing resulted in a slightly reduced useable floor area in the rooms thus the need for a waiver.

If you have any questions or concerns, please feel free to contact me.

Sincerely,

RECEIVED
DEC 30 2016
MN Dept of Health
Fergus Falls

Christopher Knoll,
Administrator
Minnewaska Community Health Services
Phone: (320) 239-7104 Email: cknoll@mchs-healthcare.org

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245537	A. BUILDING **01 - 01 - 1960 BUILDING AND ADDITIONS** B. WING _____	**12/07/2016**

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

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on December 07, 2016. At the time of this survey, 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 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. 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 43 beds and had a census of 40 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	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.

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 21, 2016

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 S5537028

Dear Mr. Knoll:

The above facility was surveyed on December 5, 2016 through December 8, 2016 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, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Lyla Burkman at (218) 308-2104, or email: lyla.burkman@state.mn.us**.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

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

Sincerely,

Mark Meath

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00477	A. BUILDING: _____ B. WING _____	12/08/2016

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

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 12/5/16, through 12/8/16, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.	2 000		

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2 000	Continued From page 2 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.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide turning and repositioning assistance as directed by the individualized care plan for 2 of 3 residents (R40, R13) who required assistance with repositioning. In addition, the facility failed to provide grooming assistance for 1 of 1 resident (R18) who required staff assistance for the removal of facial hair. Findings include: R40 was not repositioned every two hours as directed by the care plan. R40's care plan updated 11/16/16, indicated R40 was at risk for skin breakdown due to chronic wound near rectum, end stage metastatic cancer,	2 565	Corrected	1/10/17

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2 565	Continued From page 3	2 565		

protruding colostomy, pain and peri-rectal infection and directed staff to encourage repositioning every two hours and as needed. R40's hospice care plan dated 10/25/16, indicated R40 had an open area on the right buttocks due to an abscess and directed staff to provide routine turning and repositioning.

The A/B wing Turning and Repositioning worksheet dated 12/7/16, revealed R40 was last repositioned at 4:30 p.m. and indicated all residents were to be repositioned a minimum of every two hours, which included R40.

On 12/07/16, from 5:25 p.m. to 7:35 p.m., continuous observations of R40 revealed the following:

-At 5:25 p.m. R40 was observed lying in bed, on his left side. An air pressure mattress overlay was in place on R40's bed. R40 remained in bed, on left side without repositioning assistance until 7:35 p.m. at which time the director of nursing (DON) was notified.
-At 7:35 p.m., the DON was notified R40 had remained lying in bed for an observed two hours and 10 minutes without repositioning assistance and the Turning and Repositioning worksheet indicated R40 had last been repositioned at 4:30 p.m. At that time the DON confirmed R40 was at risk for skin breakdown and required assistance from staff with repositioning every two hours. The DON and nursing assistant (NA)-I proceeded to turn/reposition R40. R40 was noted to have approximately 3-4 inches of moderate amount of grey drainage from the rectal abscess on the brief. R40's buttocks had deep, light pink creases with moisture surrounding the peri-rectal area. The DON provided incontinent cares and repositioned R40 off of the left side. R40 was not

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2 565	Continued From page 4 repositioned for three hours and five minutes. On 12/07/2016, at 5:20 p.m. NA-A stated R40 required assistance of repositioning every one hour. On 12/7/16 at 7:47 p.m. the DON verified R40 required repositioning assistance every two hours and as needed. The DON confirmed R40 went three hours and five minutes without repositioning assistance and stated it was stated it was her expectation R40 would be repositioned every two hours, as directed. R13 was not repositioned every two hours as directed by the care plan. R13's care plan dated 11/1/16, indicated R13 was at risk for pressure ulcers and required encouragement to reposition every two hours and as needed. During continual observation on 12/07/16, from 11:34 a.m. to 2:59 p.m. (3 hours and 29 minutes) R13 was observed seated in a wheelchair without repositioning assistance. -At 11:34 a.m. R13 was observed seated in her wheel chair in the chapel. -At 11:42 a.m. R13 began to propel herself from the chapel when NA-D assisted to propel her to a table in the assisted dining room. R13 remained seated in the wheelchair throughout the meal time until 12:37 p.m. at which time NA-C wheeled R13 to her room. NA-C handed R13 a newspaper and left the room. -At 12:53 p.m. remained seated in the wheelchair, in her room and remained seated until 1:13 p.m. at which time R13 propelled self out of her room, across the hall way and into another resident's room. An activity aid intervened and propelled	2 565		

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2 565	Continued From page 5	2 565		

R13 back to her room. The activity aid offered to read the newspaper to R13, but was declined.
-At 1:40 p.m. NA-G stepped in to the doorway of R13's room, turned and continued down the hall. R13 remained seated in the wheelchair, in her room until 2:13 p.m. at which time LPN-D entered R13's room and offered to take R13 to activities. R13 accepted and LPN-D wheeled R13 to the main dining room.
At 2:19 p.m. R13 remained seated in the wheelchair at a dining room table and had remained there until 2:33 p.m.
-At 2:46 p.m. R13 was in the chapel for an activity. R13 remained seated in the wheelchair without repositioning assistance.

On 12/7/16 at 2:04 p.m. NA-G stated the last time R13 was assisted out of the wheelchair was at 10:00 a.m. when she was assisted to the bathroom and had not been repositioned since that time. NA-G confirmed unawareness of R13's need to be turned and repositioned and stated R13 did not need to be repositioned every two hours. NA-G verified R13 had not been assisted to toilet or reposition for greater than four hours.

On 12/7/16, at 2:51 p.m. the nurse manager (NM)-A confirmed R13 was to be repositioned every two hours.
-At 2:59 p.m. NM-A assisted R13 into the bathroom. R13's bottom was noted to have wrinkles and creases and the skin between her buttocks and inner thighs were a darker pink in color.

On 12/07/2016, at 5:16 p.m. LPN-D verified the nursing assistant care sheet directed staff to reposition R13 every two hours.

On 12/07/2016, at 7:48 p.m. the DON stated she

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2 565	Continued From page 6 had expected staff to follow R13's care plan and reposition R13 every two hours, as directed R18 was not provided with facial hair removal as directed by the care plan. R18's care plan dated 10/27/16, indicated R18 required extensive assist of two staff for grooming and directed staff to report any changes in grooming needs/abilities. On 12/6/16, at 9:16 a.m. R18 was observed seated a wheelchair, in her room. R18 was noted to have several long, white facial hairs in the center of her chin and next to the right side of her lips. When R18 was asked if the long facial hair bothered her, she replied, "yes." On 12/6/16, at 2:36 p.m. R18 was observed in bed and continued to have the long facial hair which was approximately one inch in length. On 12/7/16, at 2:23 p.m. R18 was again noted to have long facial hair. During review R18's progress notes, R18 was identified to have her shower on Mondays of each week. On 12/7/16, at 1:56 p.m. NA-C stated resident shaving was completed for all residents on a daily basis, by the nursing assistants and if any facial hair was noticed on bathing day, the bath aid would remove it. On 12/7/16, at 2:01 p.m. LPN-A confirmed R18 had long, white facial hair on her chin and next to her lip and verified she was totally dependent on staff for grooming needs which included shaving. LPN-A stated R18's shaver had been missing for	2 565		

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2 565	Continued From page 7 the past month and family was requested to purchase another one as the facility did not provide razors for residents. On 12/7/16, at 2:15 p.m. NA-D stated staff tried to shave R18 1-2 times per week when providing morning cares. However, NA-D stated she had not offered nor provided shaving assistance for R18 when she assisted her up on 12/7/16. NA-D confirmed R18 currently did have a functioning razor, and pulled the razor out of R18's top drawer. NA-D confirmed R18 had multiple long, white facial hairs on the chin and next to the lip which needed removing. On 12/7/16, at 2:51 p.m., family member (FM)-A reported R18 has always had a functioning razor in her room because she bought it for her. FM-A stated she just went into R18's room and shaved her face, and confirmed the facial hair was long and no female would want those hairs on their face. On 12/7/16, at 5:49 p.m. the DON stated she expected staff to provide grooming assistance as directed by the care plan. Review of the facility policy titled Care Plans-Comprehensive revised 10/22/16 revealed daily care and documentation must be consistent with the resident's care plan. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could implement policies and procedures related to ensuring staff implement resident care plans. The quality assessment and assurance committee	2 565		

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2 565	Continued From page 8 could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately revise the care plan to include the use of a pressure reducing boot for 1 of 3 residents (R43) reviewed for pressure ulcers and had a physician order directing the scheduled use of a pressure reducing protection device. Findings include: R43's computerized physician order dated	2 570	Corrected	1/10/17

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2 570	Continued From page 9 11/30/16, indicated R43 was to wear a pressure reducing boot to the left foot during daytime hours. R43's care plan updated on 11/30/16, indicated R43 had severe cognitive impairment and required extensive assistance with ADLs. The care plan also indicated R43 was at risk for developing pressure ulcers and on 10/21/16, had developed a bluish/purple, 4.5 centimeters (cm) x 2.5 cm fluid filled blister on her left inner heel. The care plan directed staff to anticipate all of R43's needs and to follow facility wound protocol. The care plan further identified R43's physician ordered a pressure reducing boot and indicated the boot was to be worn at night only. R43's Treatment record for December 2016, indicated on 11/24/16, a pressure reducing boot was to be worn during night time hours. However, R43's physician order directed the use during the day time hours. On 2/07/16, at 11:38 a.m. R43 was observed seated in her wheelchair, in her room, in front of her TV. R43 had sheep skin which covered the left arm of her wheelchair and a black foam cushion under her bottom in the seat of her wheelchair. R43 wore gray, no-tie shoes with a low, half back across her left heel. R43's left heel was off the back of the footrest and she was not wearing a pressure reducing boot on her left foot. A pressure reducing boot was not observed in her room. -At 12:40 p.m. following lunch in the dining room, nursing assistant (NA)-F wheeled R43 into her room in front of TV. R43's left foot was off the foot rest, and rested on the floor. No boot was in	2 570		

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2 570	Continued From page 10 place. -At 1:08 p.m. R43 was assisted into bed. R43 wore black socks, and was not wearing a pressure reducing boot on her left foot, and pressure reducing boots were not observed in her room. R43 remain in bed without the boot on until 2:40 when staff assisted her up. -At 2:40 p.m. R43 was seated in her wheelchair in the dining room having coffee with spouse. R43 was not wearing her pressure reducing boot to her left foot, and wore her gray half-back shoes. -3:29 p.m. R43 was seated in her wheelchair in the day room with spouse and was not wearing her pressure reducing boot to her left foot, and wore her gray half-back shoes. On 12/7/16, at 2:16 p.m. NA-E stated R43 required extensive assistance with all activities of daily living (ADLs) and could not communicate. She stated she was not sure what shoes R43 wore, however had worn a protective boot at night and her heels were floated when she was in bed. On 12/7/16, at 2:20 p.m. NA-D stated she thought R43 wore a boot on her left foot at night and not during the day. On 12/7/16, at 2:26 p.m. Licensed practical nurse (LPN)-A stated R43 should wear a pillow boot whenever she was in bed. At 2:40 p.m. LPN-A stated she just learned R43 was to wear the pillow boots during the night, and not during the day. She stated she understood the staff's confusion with R43's pressure boot schedule	2 570		

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2 570	Continued From page 11 because the order for it was not added to R43's care plan correctly. She stated on 11/30/16, LPN-C entered the order for R43's boots to be worn during the day, and on the same day, UM-B changed it to read R43 was to wear the pressure boot at night. On 12/8/16, at 12:36 p.m. the director of nurses (DON) confirmed R43's physician order to wear the boot during the daytime hours and verified R43's care plan had been changed to direct staff to apply the pressure reducing boot at night only. The DON stated she expected the care plan to be revised to reflect the accurate physicians order. Review of the facility policy, Care Plans-Comprehensive dated 10/22/16, identified care plans would be revised as resident condition dictated. SUGGESTED METHOD OF CORRECTION: A resident's care plan should be revised as necessary with any changes which affect the overall provision of care to a resident to ensure the appropriate care, services and treatments are provide to maximize a resident's potential for improvement. Care plans should be reviewed and revised, at a minimum on a quarterly basis. A member of the care planning team could review care plans at the time of the care conference to ensure revisions are completed timely. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		

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2 900	Continued From page 12	2 900		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow a physician prescribed order for the use of a pressure reducing boot and/or provide turning and repositioning assistance in order to heal and/or prevent a pressure related ulcer and/or the worsening of a current pressure ulcer for 2 of 3 residents (R43, R13, R40) reviewed who were at risk for pressure ulcers and/or the worsening of a pressure ulcer and observed not to be wearing the pressure reducing boot as prescribed and/or turned and repositioned timely, as directed by the individualized care plan. Findings include:	2 900	Corrected	1/10/17

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2 900	Continued From page 13 R43's pressure reducing boot was not provided as prescribed by the physician. R43's significant change Minimum Data Set (MDS) dated 10/17/16, indicated R43 had severe cognitive impairment, required extensive assistance with all activities of daily living (ADLs) and had diagnoses which included dementia, diabetes, and aphasia (non-verbal). The MDS further identified R43 was at risk for pressure ulcers, had no current pressure ulcers and had no pressure ulcer prevention interventions in place. R43's computerized physician order dated 11/30/16, indicated R43 was to wear a pressure reducing boot to the left foot during daytime hours. R43's care plan dated 11/30/16, indicated R43 had severe cognitive impairment and required extensive assistance with ADLs. The care plan indicated R43 was at risk for developing pressure ulcers and on 10/21/16, had developed a bluish/purple, 4.5 centimeters (cm) x 2.5 cm fluid filled blister on her left inner heel. The care plan directed staff to anticipate all of R43's needs and to follow the facility wound protocol. The care plan indicated R43's physician had ordered a pressure reducing boot which was to be worn at night only. However, R43 ' s physician had ordered the boot to be worn during daytime hours. R43's Treatment Record for December 2016, indicated on 11/24/16, a pressure reducing boot was to be worn during night time hours. However, R43's physician order directed the use during the day time hours. Review of R43 ' s Physician communication	2 900		

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2 900	Continued From page 14 forms revealed the following pressure related wounds: -10/21/16, R43 had a 4.5 cm x 2.5 cm blister on left inner heel. Blister was bluish/purple and appeared fluid filled. The center of blister appears darker. Physicians response was to continue current cover left metatarsal. -11/21/16, 4.0 cm X 2.5 cm left heel deep blue/purple tissue from wheelchair pedal has not resolved with betadine swabbing. Physician response was to continue to pad and protect. R43's Braden Scale (assessment for pressure ulcer risk) dated 10/19/16, indicated R43 was at risk for developing pressure ulcers, had very limited ability to respond to pressure or discomfort, and was very limited in her ability to change or correct body position. The assessment also indicated R43 had a pressure reducing device in her chair, no referrals were needed and staff were to continue with current care plan. R43's Activities of Daily Living Care Area Assessment (CAA) dated 10/24/16, indicated R43 had progressive Alzheimer's disease and required extensive assistance with ADLs. The CAA further indicated R43 was at risk for developing pressure ulcers, staff were to monitor R43's skin daily and notify the physician with any significant changes, staff were to follow the facility ' s wound protocol and to continue with the current care plan. The CAA failed to address R43's blister which developed in the facility on 10/21/16. On 2/07/16, at 11:38 a.m. R43 was observed in her room, seated in the wheelchair. R43 had sheep skin which covered the left arm of her wheelchair, a black foam cushion on the seat of the wheelchair, had gray, no-tie shoes on with a	2 900		

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2 900	Continued From page 15 low, half back across her left heel and was not wearing a pressure reducing boot on her left foot. R43's left heel was off the back of the footrest. A pressure reducing boot was not observed in her room. -At 11:59 a.m. nursing assistant (NA-D) entered R43's room and informed R43 it was time for lunch and proceeded to remove the call light from R43's hands and wheel her out of her room into hallway. -At 12:01 p.m. R43 was seated in her wheelchair in the dining room at a table. R43 was having a hard time keeping her eyes open. -At 12:07 p.m. NA-F physically assisted R43 with her with meal. R43 dozed on and off during feeding. -At 12:40 p.m. following completion of the meal, NA-F wheeled R43 into her room and positioned her in front of TV. R43's left foot was off the foot rest, and rested on the floor. -At 12:59 p.m. NA-D and NA-E entered R43's room with a mechanical lift and closed the door. -At 1:08 p.m. R43 was observed in bed on her back with her left heel on top of a flattened pillow. R43 wore black socks and was not wearing a pressure reducing boot on her left foot. A pressure reducing boot were not observed in her room. -At 1:36 p.m. and at 2:02 p.m. R43 was observed to remain in bed, on her back with her left heel under a flattened pillow. The sock remained on and a pressure reducing boot was not in place nor in her room. -At 2:26 p.m. R43 remained positioned in bed on her back with the left heel under a flattened pillow. -At 2:40 p.m. R43 was observed in the dining room, seated in her wheelchair. R43 was not wearing a pressure reducing boot to her left foot, and wore her gray half-back shoes.	2 900		

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2 900	Continued From page 16 -At 3:29 p.m. R43 was seated in her wheelchair in the day room with spouse and was not wearing her pressure reducing boot to her left foot, and wore her gray half-back shoes. -At 3:44 p.m. R43 was in her room with Unit Manager (UM-A) and spouse. R43 was not wearing a pressure reducing boot to her left foot. R43's left inner heel was observed with Um-A which revealed the following heel wounds: -0.5 cm x 0.4 cm reddened area which was soft and broken down -0.3 cm x 0.2 cm reddened area which was soft and open -0.2 cm hard blackened oval area On 12/07/16, at 2:16 p.m. NA-E stated R43 required extensive assistance with all ADLs and could not communicate. NA-E stated she was not sure what shoes R43 wore but knew R43 wore a protective boot at night and her heels were to be floated when she was in bed. On 12/07/16, at 2:20 p.m. NA-D stated R43 required extensive assistance with ADLs. She stated R43 had a black, hard blister the size of a silver dollar on her left heel. She stated she felt R43 developed the blister to her left heel because staff had not kept her feet elevated enough and was not repositioned all the time. NA-D stated staff tried to reposition R43 every two hours and also elevate her feet with a pillow or two and thought R43 wore a boot on her left foot at night and not during the day. NA-D stated R43 was not to wear socks when she had the boot on. On 12/07/16, at 2:26 p.m. licensed practical nurse (LPN)-A stated R43 required total care from staff, had a huge blood blister on her left heel which she thought was a pressure related ulcer. She stated staff thought the blister was caused from	2 900		

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2 900	Continued From page 17 her wheelchair foot pedals and/or someone had not put her shoes on all the way which caused friction. LPN-A stated R43's heel was to be protected by making sure staff were putting her shoes on correctly, because R43's shoes did not have not full backs on them, and confirmed R43 had on the same shoes as when she developed the pressure ulcer to her left heel. LPN-A also stated staff were to float 43's heels and apply a pillow boot when she was in bed. She stated R43 had an alternating air mattress and was repositioned and cleansed properly. LPN-A stated R43 should have had her boots on at this time and would go check to see if she had them on. -At 2:40 p.m. LPN-A returned and stated she had learned R43 was to wear the pillow boots during the night, and not during the day. She stated she understood the confusion with R43's boot schedule because the order was not documented correctly on R43's care plan. LPN-A stated on 11/30/16, LPN-C had entered the order for R43's boots to be worn during the day, and on 11/30/16, UM-B changed the care plan to read R43 was to wear boots at night. LPN-A verified there were no progress notes associated with the physician order for R43's protective boot and stated " it was bizarre. " In addition, LPN-A stated R43's pressure reducing boot was applied originally applied on 10/21/16, but she could not find the original order for the boot dated 10/21/16. On 12/7/16, at 3:29 p.m. family member (FM)-B stated R43 had worn the protective boot every day until yesterday as her understood the scab had fallen off and R43 did not need the boot anymore. RM-B stated R43 had a dead blood blister the size of a quarter before Thanksgiving and R43 had worn the same shoes which had nothing to do with her developing the blister.	2 900		

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2 900	Continued From page 18 FM-B stated he thought the blister was caused by the foot pedal guards on her wheelchair. FM-B stated the current pressure ulcer interventions for the blister were betadine swabs and wearing the boot. On 12/8/16, at 12:36 p.m. the director of nurses (DON) stated once R43's blister was identified, they determined it was caused from pressure from her wheelchair foot pedal bars. She stated they had removed the bars and applied a protective boot to R43 ' s left foot which she wore all day and night. The DON stated her and UM-B had discussed R43 wearing the boot during the day and both felt it was a dignity issue so on 11/30/16, UM-B had changed the schedule of the boot to night time use only. The DON stated she expected the physician order to be accurate and followed as written and for the order to match the care plan. She stated she expected the care plan to be accurately revised to reflect the actual physicians order. On 12/08/16, at 1:50 p.m. The DON confirmed R43 was at risk for developing pressure ulcers and verified R43 ' s medical record lacked any progress notes related to the use of the protective boot and she was unable to find the original physician's order for the boot. R40 was at risk for pressure related ulcers and was not provided timely repositioning, as directed. R40's admission MDS dated 10/31/16, indicated R40 was cognitively intact and had diagnoses which included malignant neoplasm of colon and liver, rectal abscess and pain. The MDS indicated R40 was at risk for pressure ulcers and required supervision, cueing and oversight along	2 900		

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2 900	Continued From page 19 with one staff assistance for bed mobility and transferring. The MDS did not identify any pressure ulcer prevention interventions in place. R40's Pressure Ulcer Care Area Assessment (CAA) dated 11/10/16, indicated R40 had an open abscess near his rectum with wound drainage which put him at risk for skin breakdown. The Minnewaska Lutheran Home Admission Skin Condition form dated 10/1/16, revealed R40 had an open area on right buttocks. The form did not identify any pressure ulcer interventions had been put into place. R40's Braden Scale dated 10/31/16, indicated R40 was at risk of skin breakdown. R40's care plan dated 11/16/16, indicated R40 was at risk for skin breakdown due to chronic wound near rectum that had purulent drainage, end stage metastatic cancer, protruding colostomy, pain and peri-rectal infection. R40's care plan directed staff to encourage repositioning every two hours and as needed. R40's hospice care plan dated 10/25/16, indicated R40 had an open area on the right buttocks due to an abscess. Various interventions had been put in place which included routine turning and repositioning. The A/B wing Turning and Repositioning worksheet dated 12/7/16, revealed R40 had been last repositioned at 4:30 p.m. The form revealed all the residents were to be repositioned a minimum of every two hours, which included R40. On 12/7/16, at 5:25 p.m. R40 was observed in bed lying on his left side. An air mattress overlay	2 900		

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2 900	Continued From page 20	2 900		

was observed on his bed. Continuous observation of R40 continued until 7:35 p.m. in which R40 remained in bed on his left side without repositioning.
-At 7:35 p.m. the DON was notified R40 had remained lying in bed for an observed two hours and 10 minutes. The DON confirmed R40 was at risk for skin breakdown and required assistance from staff to turn and reposition every two hours. The DON and NA-I proceeded to assist R40 with incontinent cares and repositioning. When R40 ' s incontinent brief was removed, R40 ' s rectal wound was noted to have approximately 3-4 inch in diameter of gray drainage on the brief. R40's buttocks had deep, light pink creases with moistness surrounding the peri-rectal area. The DON and NA-I proceeded to complete perineal cares and repositioned R40 off of his left side. R40 had remained in the same position for a total of 3 hours and 5 minutes. According to the A/B wing Turning and Repositioning worksheet dated 12/7/16, R40 was not turned and repositioned for three hours and five minutes.

On 12/7/2016, at 5:20 p.m. NA-A stated R40 required assistance with repositioning every one hour.

On 12/7/16 at 7:47 p.m. the DON confirmed the aforementioned observations and verified R40 required turning and repositioning assistance every two hours, and as needed. The DON verified according to the A/B wing Turning and Repositioning worksheet, R40 was last repositioned at 4:30 p.m. and stated her expectation was for staff to reposition R40 every two hours, as directed.

On 12/8/16 at 8:49 a.m. during phone interview with R40's hospice registered nurse (RN)-D

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2 900	Continued From page 21 verified R40 was at high risk for skin breakdown and stated R40 required good perineal cares and would expect R40 to be repositioned at least every two hours. R13 was identified at risk for pressure ulcers and every two hour turning and repositioning was not provided as directed by the care plan. R13's Physician Order Report dated 10/19/16, identified R13's diagnoses included Parkinson's disease, dementia and peripheral vascular disease, (a blood circulation disorder). R13's quarterly MDS dated 10/25/16, indicated R13 was at risk for pressure, required extensive assist of one staff for bed mobility and transfers and utilized a wheelchair cushion pressure reducing device. R13's Braden Scale for Predicting Pressure Sore Risk, dated 10/24/16, indicated R13's skin was occasionally moist, R13 spent most of each shift in bed or chair, had slightly limited mobility, ate adequately, and had a potential problem with friction and shear. The Braden indicated R13 was at risk for pressure sores, had a pressure reducing device for her chair and the current care plan interventions was to continue. R13's Tissue Tolerance Test dated 10/20/16, indicted R13 could tolerate two hours seated or laying in one position without change to skin condition. R13's Activities of Daily Living Care Area Assessment dated 2/2/16, indicated R13 was at risk for skin break down and every two hour, and as needed, repositioning interventions were in place.	2 900		

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R13's care plan revised 11/1/16, indicated R13 was at risk for pressure ulcers and required encouragement to reposition every two hours and as needed.

During observation on 12/07/16, from 11:34 a.m. to 2:59 p.m. (3 hours and 29 minutes) R13 was observed seated in a wheelchair without having been repositioned.
-At 11:34 a.m. R13 was observed in the chapel, seated in her wheelchair.
-At 11:42 a.m. R13 began to propel herself in the wheelchair from the chapel when NA-D walked up behind R13's wheelchair and propelled her to a dining room table. R13 remained in the dining room, seated in the wheelchair until 12:37 p.m. at which time, NA-C wheeled R13 to her room, handed R13 a newspaper and exited the room.
-At 12:53 p.m. R13 was observed seated in her wheelchair, in her room.
-At 1:08 p.m. R13 remained in the wheelchair, asleep.
-At 1:10 p.m. R13 turned the wheel chair towards the window and sat quietly.
-At 1:13 p.m. R13 propelled herself out of the room, across the hall and into another resident's room. An activity aid intervened and wheeled R13 back to her room. The activity aid offered to read the newspaper to R13, but was declined.
-At 1:40 p.m. NA-G stepped into the doorway of R13's room, turned and continued down the hall.
-At 1:45 p.m. R13 remained seated in the wheelchair in her room. Two nursing assistants and the LPN and a student nurse were in the room next door with another resident.
-At 1:52 p.m. R13 remained seated in the wheelchair in her room.
-At 2:13 p.m. LPN-D entered R13's room and offered to assist R13 to activities. R13 accepted

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2 900	Continued From page 23 and LPN-D wheeled R13 to the main dining room. R13 was not offered repositioning assistance. -At 2:19 p.m. R13 remained seated in the wheelchair at a dining room table with four other residents. R13 drank from a covered mug with a straw and ate a dessert. -At 2:33 p.m. R13 remained at the table drinking from the covered mug. At 2:46 p.m. R13 was in the chapel for an activity. She remained seated in the wheelchair. On 12/7/16 at 2:04 p.m. NA-G stated nursing assistant staff used a book at the nurse station to write down what cares were provided for a resident and at what time. The form was titled A/B wing Turning and Repositioning Worksheet which was dated 12/7/16. NA-G stated the oncoming staff transferred the last times care was provided and documented for each resident on to a new form. NA-G confirmed night staff had written 4:00 a.m. for R13. However, NA-G stated she was unaware of what cares night staff had provided R13 at 4:00 a.m. and verified it could have been anything from toileting to visual checking on her. NA-G confirmed the following was also documented on the form by the day shift staff: At 8:10 a.m. R13 was assisted up from bed. At 10:00 a.m. R13 was assisted to the toilet. At 10:30 R13 was observed at church. At 1:00 p.m. checked. NA-G verified R13 had not been repositioned for greater than four hours. NA-G was also unaware of R13 ' s turning and repositioning schedule and stated R13 was not to be repositioned every two hours or anything like that. On 12/7/16, at 2:30 p.m. shift change was occurring at the A/B wing nurses station. On 12/7/16, at 2:38 p.m. NA-H stated R13 was	2 900		

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2 900	Continued From page 24	2 900		

visually checked on every half hour R13 did not have a repositioning schedule but would be repositioned when toileted. NA-H verified she had not toileted R13 this afternoon and the Turing and Repositioning Worksheet identified R13 was last toileted at 10:00 a.m. which was four and a half hours earlier.

On 12/07/16, at p.m. 2:51 p.m. nurse manager (NM)-A verified R13 should be repositioned every two hours and expected staff to do so. NM-A reviewed the Turning and Repositioning form and verified there was no documentation of R13 having been repositioned or refusing repositioning. At 2:59 p.m. NM-A assisted R13 into the bathroom and assisted R13 to stand with the use of a gait belt and assistive bars bolted to the bathroom wall. R13's bottom was noted to have wrinkles and creases and the skin between her buttocks and inner thighs were dark pink in color. NM-A indicated she would direct staff to be diligent with repositioning R13 every two hours because of her recent decline and was no longer able to stand independently.

On 12/07/2016, at 5:16 p.m. LPN-D stated R13 had a recent decline in physical and mental ability, was at risk for pressure ulcers and required repositioning every two hours. LPN-D verified the nursing assistant care sheet directed staff to reposition R13 every two hours.

On 12/07/2016, at 7:48 p.m. the DON stated she had expected staff to reposition R13 every two hours according to the tissue tolerance assessment and care plan.

The facility Prevention of Pressure Ulcers policy reviewed 12/3/15, indicated pressure related ulcers were usually formed when a resident

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2 900	Continued From page 25 remained in the same position for an extended period of time causing increased pressure or a decrease of circulation (blood flow) to that area, which destroyed the tissues. Risk factors and preventive actions for a person in a chair included changing positions every two hours and use a foam, gel, or air cushion to relieve pressure. The facility Skin Care policy dated 12/3/16, indicated residents who had pressure sores would receive the recommended treatment and services to promote healing and prevent new sores from developing. The facility Turning a Resident on his/her Side policy reviewed 3/3/2000, indicated the purpose was to provide comfort to the resident, to prevent skin irritation and breakdown and to promote good body alignment. The facility Care Plans-Comprehensive policy revised 10/22/16, indicated daily care and documentation must be consistent with the resident's care plan. The Director of Nursing, and/or designee could assure policies and procedures were current, implemented, and monitored to assure nursing staff impliment physician orders, and assessed interventions for pressure ulcer treatment and prevention. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 900		

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2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide grooming services related to the removal of facial hair for 1 of 1 resident (R18) observed to have long facial hair which was not removed by staff. Findings include: R18's annual Minimum Data Set (MDS) dated 10/21/16, indicated R18 had moderate impaired cognition and required extensive assist of two staff for completing personal hygiene including shaving. R18's Activities of Daily Living Care Area Assessment (CAA) dated 10/28/16, indicated R18 required total to extensive assistance of two staff for activities of daily living due to left sided paralysis from a stroke and a traumatic brain injury (TBI). R18's care plan dated 10/27/16, indicated R18 required extensive assist of two staff for grooming and directed staff to report any changes in grooming needs/abilities.	2 920	Corrected	1/10/17

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2 920	Continued From page 27 On 12/6/16, at 9:16 a.m. R18 was observed in her room, seated in a wheelchair. R18 was noted to have several long, white facial hairs in the center of her chin and next to the right side of her lips. When R18 was asked if the long facial hair bothered her, she replied, "yes." On 12/6/16, at 2:36 p.m. R18 was observed in bed and continued to have the long facial hair which was approximately one inch in length. On 12/7/16, at 2:23 p.m. R18 was again noted to have long facial hair. During review R18's progress notes, R18 was identified to have her shower on Mondays of each week. On 12/7/16, at 1:56 p.m. nursing assistant (NA)-C stated shaving was completed for all residents on a daily basis by the nursing assistants assigned to provide care to the resident. NA-C stated if any facial hair was noticed on bath day, she would remove it. On 12/7/16, at 2:01 p.m. licensed practical nurse (LPN)-A confirmed R18 was totally dependent on staff for grooming, including shaving and stated R18's shaver had been missing for the past month. LPN-A stated R18's family was requested to purchase another one because the facility did not provide razors for the residents. LPN-A confirmed R18 had long, white facial hair on her chin and next to her lip which needed to be removed. On 12/7/16, at 2:15 p.m. NA-D confirmed R18 needed extensive assistance from staff for shaving and stated staff tried to shave R18 1-2 times per week. NA-D stated staff shaved the residents when they provided morning cares.	2 920		

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2 920	Continued From page 28 NA-D verified she had assisted R18 with morning cares on 12/7/16, and had not offered nor provided shaving cares and had not attempted to shave R18 throughout the day. NA-D stated R18 currently did have a functioning razor and proceeded to pull the razor out of R18's top drawer. NA-D confirmed R18 had multiple long, white facial hairs on the chin and next to the lip which needed to be removed. On 12/7/16, at 2:51 p.m. family member (FM)-A stated R18 had always had a functioning razor in her room because she bought it for her. FM-A stated she had just went into R18's room and shaved her face, and confirmed the facial hair was long and no female would want those hairs on their face. On 12/7/16, at 5:49 p.m. the director of nursing (DON) verified R18 was depended on staff for grooming needs which included shaving and stated she expected staff to provide shaving needs with morning cares. A facility policy related to grooming was requested, but not provided. SUGGESTED METHOD OF CORRECTION: The facility could review policies and procedures for providing shaving/grooming needs as directed by the assessed needs of residents and provide education to nursing staff to follow cares as directed by the care plan. The facility could develop and implement an auditing system to ensure on-going compliance.	2 920		

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2 920	Continued From page 29 TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 920		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate infection control measures were implemented for a communally used glucometer/blood glucose meter. This practice had the potential to effect all 6 residents (R3, R16, R20, R25, R35, R41) who required blood glucose monitoring on the A/B wings. Findings include: On 12/07/2016, at 5:47 p.m. licensed practical nurse (LPN)-D was observed to cleanse her hands, gather supplies from the cart and donned gloves. Behind a curtain in a small storage area, LPN-D wiped R-16's finger with an alcohol wipe, air dried the finger and used a disposable lancet to prick R16's finger. LPN-D used the glucometer (a medical device used to measure sugar levels in blood) to check R-16 ' s blood sugar level. LPN-D returned to the medication cart, disposed of the disposable items and placed the glucometer on the top of the cart.	21375	Corrected	1/10/17

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21375	Continued From page 30	21375		

-At 5:52 p.m. LPN-D placed a needle on the Humalog insulin pen and turned the dial to 22 units. LPN-D obtained an alcohol wipe and returned behind the curtain and administered R16's insulin. LPN-D returned to the medication cart, placed the insulin needle into the sharps container (container for used medical needles and equipment), disposed of the alcohol wipe and gloves. Without cleaning or disinfecting the glucometer, LPN-D picked it up from the top of the medication cart and placed it into the top drawer of the medication cart.

-At 6:05 p.m. LPN-D obtained the same glucometer, meter strip, alcohol wipe and R41's Levemir insulin pen. LPN-D went behind the curtain in the hall with R41. LPN-D used hand sanitizer, donned gloves, placed the strip into the glucometer machine and grasped R41's left hand in order to obtain a blood sample. At this time the surveyor intervened. LPN-D did not proceed to check R41's blood sugar and returned to the medication cart with the glucometer.

-At 6:08 p.m. LPN-D verified the intent to use the multi-use glucometer to check R41's blood sugar without disinfecting it after it had been used to check R16's blood sugar and verified this practice had the potential to spread infection. LPN-D stated the usual facility practice was to disinfect the communally used glucometer after each use. LPN-D verified all diabetic residents currently served by this medication cart had personal glucometers which were kept in their rooms, however, the communally used glucometer from the cart was used when the residents were away from their rooms.

On 12/08/2016, at 12:21 p.m. the director of nursing (DON) verified a glucometer was

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21375	Continued From page 31 available in the medication cart for residents who did not have a personal glucometer in their room. The DON stated she expected the multi-use glucometer machines be disinfected between resident use to prevent the spread of germs and bacteria and to follow basic infection control practices. The DON indicated all nursing staff were aware of the infection control practice. The facility policy titled Maintaining the Glucometer/Cleaning, revised 12/5/15, indicated it was policy to advise nursing staff to clean and disinfect blood glucose meters between each resident to avoid possible cross-contamination. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to disinfecting the communal glucometer in order to prevent the spread of infection. The DON or designee could develop and implement an auditing system to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's	21426		1/10/17

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21426	Continued From page 32 Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Tuberculin Skin Test (TST) had been completed, as required for 1 of 5 residents (R43), and for 2 of 5 employees (E4 and E5) reviewed for the tuberculosis (TB) program. Findings include: R43 was admitted to the facility on 3/24/15. Review of the R43's immunization record revealed the TST screen was completed 3/24/2015. However, the record lacked documentation of the date and interpretation of the results for the first and second TST. E4 was hired by the facility on 9/21/2016. Review of E4's employee record revealed the TST screen was completed 9/21/16, the first step TST was	21426	Corrected	

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21426	Continued From page 33 administered on 9/21/16, and was interpreted on 9/23/16. However the record lacked documentation of the date and interpretation of the results of the second step TST. E5 was hired by the facility on 10/16/16. Review of E4's employee record revealed the TST screen was completed 9/26/16, the first step TST was administered on 9/27/16, and was interpreted on 9/29/16. However the record lacked documentation of the date and interpretation of the results of the second step TST. During interview on 12/8/16, at 12:36 p.m. the director of nursing (DON) confirmed the second step TST was not complotted for E4 and E5. She stated she expected staff to follow their procedures, and stated they had forgot. The facility also failed to provide documentation of the date and interpretation of the results for R43's first and second step TST. The facility's Tuberculosis Control Plan/Risk Assessment policy dated 1/7/14, identified all staff and residents of the nursing home would receive an initial two-step Mantoux unless they had a history of a positive Mantoux, which required a chest X-ray to determine Tuberculosis risk. SUGGESTED METHOD OF CORRECTION: The infection control nurse or designee could review the TB policies and procedures to ensure required information is included. Appropriate staff could be educated regarding requirements. Audits could be could be conducted and the	21426		

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21426	Continued From page 34 results reviewed at the quality committee meetings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21630	MN Rule 4658.1350 Subp. 2 A.B. Disposition of Medications; Destruction Subp. 2. Destruction of medications. A. Unused portions of controlled substances remaining in the nursing home after death or discharge of a resident for whom they were prescribed, or any controlled substance discontinued permanently must be destroyed in a manner recommended by the Board of Pharmacy or the consultant pharmacist. The board or the pharmacist must furnish the necessary instructions and forms, a copy of which must be kept on file in the nursing home for two years. B. Unused portions of other prescription drugs remaining in the nursing home after the death or discharge of the resident for whom they were prescribed or any prescriptions discontinued permanently, must be destroyed according to part 6800.6500, subpart 3, or must be returned to the pharmacy according to part 6800.2700, subpart 2. A notation of the destruction listing the date, quantity, name of medication, prescription number, signature of the person destroying the drugs, and signature of the witness to the destruction must be recorded on the clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview and document	21630	Corrected	1/10/17

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21630	Continued From page 35	21630		

review, the facility failed to properly secure controlled substances while waiting for destruction for 1 of 1 resident (R39) who currently utilized Fentanyl patches. This practice had the potential to affect all 40 residents who resided in the facility.

Findings include:

On 12/8/16, at 9:43 a.m. during a random review of the A-B wing medication storage cart, a black bound narcotic (medications that have a high likelihood of abuse) medication log book was observed unsecured, on top of the cart. A used Fentanyl narcotic patch was observed tucked inside the front cover of the. At this time, registered nurse (RN)-A stated she had placed R39's used Fentanyl patch in the narcotic book on 12/8/16, at 6:30 a.m. after she had applied R39's new Fentanyl patch. RN-A stated she had placed the used patch in the narcotic book until a staff member was available to witness the destruction of it. RN-A confirmed the narcotic book and Fentanyl patch had been unsecured on top of the medication cart since that time. RN-A stated the narcotic book did not fit into the double locked compartment inside the medication cart and the facility's current process of storing used Fentanyl patches was not the perfect system.

R39's individual narcotic record, page 91, indicated a new Fentanyl patch 75 micrograms (mcg) was applied on 12/8/16, at 6:30 a.m.

On 12/8/16, at 9:48 a.m. RN-A and RN-B were observed to dispose of the used Fentanyl patch into the sewer, both nurses signed R39's narcotic record.

On 12/8/16, at 10:30 a.m. the director of nursing

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21630	Continued From page 36 (DON) stated the nurse tucked the used Fentanyl patch into the narcotic book for storage until a witness was available for destruction. The DON confirmed the narcotic book did not fit into the medication cart's double locked compartment and was placed unsecured on top of the medication cart which was the facility's usual practice for storage of used Fentanyl patches until destruction. The DON acknowledged controlled medication remained in the used Fentanyl patches. The facility's Controlled Substances Containing Transdermal Delivery System (i.e.: fentanyl) policy dated 8/6/15, indicated all controlled substances must be stored in the medication cart in a locked container, separate from containers for any non-controlled medications or in the locked medication room in a locked cabinet. This container must remain locked at all times, except when it is accessed to obtain medications for residents. Used Fentanyl patches must be flushed down the hopper in the utility room and be witnessed by another nurse. Both nurses are required to sign off in the narcotic record. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) could develop and implement policies and procedures related to the disposition of narcotic medications, such as used fentanyl/duragesic patches waiting for destruction. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days.	21630		

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21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility to maintain resident bathrooms in a clean and sanitary manner for 15 of 30 resident bathrooms on the A and C wings (A26, A28, A30, A32, A34, C101, C103, C104, C106, C108, C109, C110, C111, C113, C116) observed to be in need of cleaning and repair. Findings include: During resident room observations on 12/5/15, the following was identified: -Room A26, the off-white bathroom tile floor was dirty and stained dark behind the toilet -Room A28, the off-white bathroom tile floor was dirty and stained dark behind the toilet -Room A30, the caulking around the white toilet base was dark brown, and the off-white floor tile behind the toilet was dirty and stained dark -Room A32, the off-white bathroom tile floor had built-up dirt in the corners	21695	Corrected	1/10/17

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21695	Continued From page 38 -Room A34, the off-white bathroom tile floor was dirty and stained dark, and the bathroom sink had green lime scale build up on the unit and the handles -Room C101, the off-white bathroom tile floor was dirty, the bathroom door was scratched and damaged towards the bottom of the door, and the bathroom sink had green lime scale build up on the unit and the handles. -Room C103, the off-white bathroom tile floor was dirty, the bathroom door was scratched and damaged towards the bottom of the door, and the bathroom sink had green lime scale build up on the unit and the handles -Room C104, the off-white bathroom tile floor was stained and dirty, and the bathroom sink faucet had green lime scale build up on the unit and the handles. -Room C106, had a large rust stain on the off-white bathroom floor tile behind the toilet which measured approximately 4 inches x 4 inches, and the bathroom faucet had green lime scale build up on the unit and the handles. -Room C108, had a large rust stain to the off-white bathroom floor tile behind the toilet which measured approximately 4 inches x 4 inches, and the bathroom faucet had green lime scale build up on the unit and the handles. -Room C109, the bathroom sink had built up green lime scale on the unit and the handles. -Room C110, the bathroom sink had built-up green lime scale on the unit and the handles, the	21695		

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	00477	A. BUILDING: _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21695	Continued From page 39 off-white bathroom floor tile was dirty and stained underneath the sink, on the sides of toilet, and behind the toilet. -Room C111, had significant scrapes to the bathroom wall opposite of the toilet, and the bathroom sink had built-up green lime scale on the faucet and the handles, and the off-white bathroom floor tile was dark, and in poor condition. -Room C113, the bathroom faucet had built-up green lime scale on the unit and on the handles. -Room C116-1 and C116-2, the bathroom faucet had built up green lime scale on the unit and the handles. On 12/08/16, at 9:10 a.m. Environmental Services Director (ESD) stated he was responsible for all facility maintenance, housekeeping and laundry services. He stated staff were to complete a repair request slip, and leave it at the C nurses station in the designated container. He stated they checked the container for slips at least daily. He stated when they removed the repair request slips from the C nurses station they prioritized and completed the repairs. He stated after they completed a repair they signed the slips, and stored them in a box on the tool shelf in the boiler room. He stated all staff were trained annually on how to complete the request slips for repairs. He confirmed he was not aware of the resident room concerns, and had not received any repair request slips for the identified concerns. He stated he was short a couple of staff, and they hadn't had time to maintain the resident rooms the way they should be. He stated there was no excuse for the resident bathrooms to look like they did.	21695		

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21695	Continued From page 40 On 12/08/16, at 12:36 p.m. director of Nursing (DON) stated she was aware of the dirty resident bathrooms on A wing, and stated she just assumed resident bathrooms on the other wings were bad too. She stated she had mentioned the dirty bathrooms to the ESD in the past, and stated she expected the ESD to clean and maintain the resident rooms. She stated she felt resident rooms had not been maintained because the facility was short staffed in housekeeping and maintenance. Review of the facility policy, "Bathrooms" dated 7/21/09, identified bathrooms would be maintained in a clean and sanitary manner and shall be cleaned on a daily basis. SUGGESTED METHOD OF CORRECTION: The director of maintenance could ensure a reporting system was in place and necessary repairs were made. Audits could be conducted to ensure staff are cleaning and making timely repairs. The results could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		
22155	MN Rule 4658.4105 Subp. 2 Bedroom Design; New Construction Subp. 2. Usable floor area. The usable floor area and the arrangement and shape of the bedroom must provide space for furnishings, for	22155		1/10/17

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22155	Continued From page 41 the free movement of residents with physical handicaps, and for nursing procedures. "Usable floor area" does not include spaces occupied by toilet rooms, vestibules, permanently installed wardrobes, lockers, closets, or heating units. The usable floor area per bed must be at least 100 square feet per resident in double bedrooms, and at least 120 square feet in single bedrooms. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the 13 single resident rooms on the A-wing had at least 100 square feet of useable floor space for 12 of 12 residents (R8, R12, R13, R14, R17, R20, R22, R24, R25, R27, R35, R39) who currently resided in those rooms. Findings include: During the tour of A-wing on 12/5/16, at 12:00 p.m. R8, R12, R13, R14, R17, R20, R22, R24, R25, R27, R35 and R39's rooms were observed to not have at least 100 square feet of useable floor space, as required. On 12/5/16, at 1:58 p.m. R17 was observed in bed. The room appeared neat and orderly. -At 2:28 p.m. R8 indicated she was pleased with her room and was able to have all the things she needed in her room, including her knitting supplies. -At 2:45 p.m. R39 reported no concerns with the small room size. -At 3:02 p.m. R13 was observed propelling herself in a wheelchair in her room. R13 was not observed to have difficulty moving about the room.	22155	Corrected	

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22155	Continued From page 42 -At 3:17 p.m. R20 indicated he liked his room. -At 3:36 p.m. R25 reported no concerns with the small room size. On 12/06/2016 08 a.m. R24 reported no concerns with the small room size. On all days of the survey R22 was unavailable to be interviewed due to her busy schedule. R12 also was not interviewed. All rooms appeared clean, orderly, and home like. On 12/08/2016, at 9:10 a.m. nursing assistant (NA)-F verified the rooms on A-wing were a little tight when assisting residents and even more so when a mechanical lift was needed. NA-F stated staff were able to manage all resident needs even though the area was small. On 12/08/2016 9:17 a.m. R12 refused interview. On 12/8/16, at 12:19 p.m. the director of nursing (DON) indicated she was aware of the A wing rooms not being the required square footage and stated she had not had any resident complaints regarding the small room size. On 12/8/16, at 1:04 p.m. R14 stated although the room was small, the benefits of a private room with its own bathroom and a nice view were worth having the smaller living space. R14 stated her daughter was happy with the room and had told R14 the room felt cozy. On 12/8/16, at 1:07 p.m. R27 reported she liked her room, had been offered to move to a larger room, however, had declined and stated "it is home." On 12/8/16, at 2:29 the administrator verified the	22155		

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22155	Continued From page 43 resident rooms on the A-wing did have less than 100 square feet of usable space and the facility would apply for a waiver for this requirement. On 12/8/16, at 2:38 p.m. the facility environmental services director (ESD) stated the single rooms on the A-wing were less than the required 100 square feet of useable floor space, and the facility would be applying for a room wavier. The ESD stated there were no problems maintaining cleaning and upkeep of the rooms. SUGGESTED METHOD FOR CORRECTION: The administrator could apply for the federal waiver and monitor identified rooms on an ongoing basis for safety and resident satisfaction. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days.	22155		