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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LWDY

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00681

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245440**

2. STATE VENDOR OR MEDICAID NO. (L2) **765240200**

3. NAME AND ADDRESS OF FACILITY
(L3) **JANESVILLE NURSING HOME**
(L4) **102 EAST NORTH STREET**
(L5) **JANESVILLE, MN** (L6) **56048**

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 **4/10/2017** (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) **09/30**

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

12.Total Facility Beds **40** (L18)

13.Total Certified Beds **40** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	40			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathy Hahn, HFE NE II 04/28/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 04/28/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **02/01/1987** (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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245440

April 28, 2017

Mr. R. Peter Madel III, Administrator
Janesville Nursing Home
102 East North Street
Janesville, MN 56048

Dear Mr. Madel Iii:

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 March 23, 2017 the above facility is certified for:

40 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 40 skilled nursing facility beds located in rooms .

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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 28, 2017

Mr. R. Peter Madel III, Administrator
Janesville Nursing Home
102 East North Street
Janesville, MN 56048

RE: Project Number S5440027

Dear Mr. Madel III:

On March 10, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 23, 2017. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On April 10, 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 February 23, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 23, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 23, 2017, effective March 23, 2017 and therefore remedies outlined in our letter to you dated March 10, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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
245440 Y1	A. Building B. Wing Y2	4/5/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

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 F0279	Correction	ID Prefix F0282	Correction	ID Prefix F0309	Correction
Reg. # 483.20(d);483.21(b)(1)	Completed	Reg. # 483.21(b)(3)(ii)	Completed	Reg. # 483.24, 483.25(k)(l)	Completed
LSC	03/23/2017	LSC	03/23/2017	LSC	03/23/2017
ID Prefix F0318	Correction	ID Prefix F0329	Correction	ID Prefix F0428	Correction
Reg. # 483.25(c)(2)(3)	Completed	Reg. # 483.45(d)(e)(1)-(2)	Completed	Reg. # 483.45(c)(1)(3)-(5)	Completed
LSC	03/23/2017	LSC	03/23/2017	LSC	03/23/2017
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	
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
	KS/kfd	4/28/2017	03048	4/5/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
2/23/2017

☐ 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: LWDY

Facility ID: 00681

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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2. STATE VENDOR OR MEDICAID NO. (L2) **765240200**

3. NAME AND ADDRESS OF FACILITY
(L3) **JANESVILLE NURSING HOME**
(L4) **102 EAST NORTH STREET**
(L5) **JANESVILLE, MN** (L6) **56048**

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 **02/23/2017** (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	
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FISCAL YEAR ENDING DATE: (L35) **09/30**

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Compliance Based On:
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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** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	40			
(L37)	(L38)	(L39)	(L42)	(L43)

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1861 (e) (1) or 1861 (j) (1): (L15)

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17. SURVEYOR SIGNATURE Date :
Kathy Hahn, HFE NE II 04/07/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 04/07/2017 (L20)

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

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____ 2. Facility is not Eligible
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26. TERMINATION ACTION: (L30)
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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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 6733
March 10, 2017

Mr. R. Peter Madel III, Administrator
Janesville Nursing Home
102 East North Street
Janesville, MN 56048

RE: Project Number S5440027

Dear Mr. Madel III:

On February 23, 2017, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Health Regulation Division
Licensing and Certification Section
1400 E. Lyon St.
Marshall, MN 56258
Telephone: (507) 476-4233 Fax: (507) 537-7194

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 April 4, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

sooner than the latest correction date on the PoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 23, 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 August 23, 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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

Feel free to contact me if you have 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

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING _____ B. WING _____	02/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 279		3/23/17

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

Electronically Signed | 03/24/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING _____ B. WING _____	02/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(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 279	Continued From page 1 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement a comprehensive plan of care for preventive skin	F 279	We disagree with the surveyors findings in this area. We find them to be nothing more than observational findings that fail	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245440	A. BUILDING _____ B. WING _____	02/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

(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 279	Continued From page 2 care for 1 of 3 residents (R3) reviewed for contractures. Findings include: During review of the annual Minimum Data Set (MDS) assessment dated 11/23/16, R3 was identified with impairment of range of motion (ROM) in upper extremities that included the hands and required extensive assistance in activities of daily living (ADL's). Documentation on the MDS indicated R3 did not receive occupational therapy (OT) or physical therapy (PT). Review of the annual Care Area Assessment (CAA) dated 11/23/16, identified R3 with impaired hand dexterity and functional limitation in upper extremity ROM. Review of R3's plan of care identified: extensive assistance of staff with all ADL's, experienced decreased mobility and muscle weakness and R3 attempts to feed self at times but is unable. Review of the OT plan of care dated 8/29/16 through 9/8/16, identified R3 had an evaluation for contracture prevention. R3 has a right wrist and hand orthosis (WHFO) to reduce further progressing/development and prevention of contractures but had been noncompliant with wearing the splint. The discharge notes dated 9/8/16, indicated R3 did not meet her goal with the application of the splint due to anxiety and being resistive with application. Recommendations by OT were to discontinue the splint and for nursing staff to monitor skin and maintain skin integrity in the palm of her hand. During observation and interview on 2/22/17, at 1:27 p.m. R3 had both hands clenched tightly.	F 279	to rise to the level of a deficient practice. However, in the spirit of cooperation we have taken the following steps. As the surveyors note in their comments, Resident #3 had previously been seen by Occupational Therapy. While surveyors were in the building an intervention of washing and thoroughly drying hands was added to the residents care list. Occupational therapy was asked to re-evaluate resident. New palm protectors have been added to the plan of care and the resident has been more accepting of this type of protector. Resident has been discharged from OT with instructions for range of motion, hygiene care, and palm protector application and usage. This information has been added to the Care Plan and nursing assistant cares. Charge Nurses will spot check to ensure cares are being provided and protector is in use as recommended. To promote continuity of care and to ensure the highest level of care, the nursing and therapy departments will meet weekly and discussion of discharge plans will be part of this meeting. The goal will be to ensure a smooth transition from skilled therapy. The Director of Nursing will monitor this area and report findings back to the Quality Assurance Committee at its quarterly meeting.	

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	245440	A. BUILDING _____ B. WING _____	02/23/2017

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F 279	Continued From page 3	F 279		

When the surveyor asked R3 to open her clenched hands, R3 attempted but was unable. The trained medication assistant (TMA)-B who was present, manually opened R3's hands, but could only open them partially before resistance was noted. R3 denied discomfort during this time. When TMA-B opened R3's right hand, the palm was whitish, moist, slightly reddened in areas and very odorous. TMA-B indicated R3 did not have a splint nor a hand protector and did not receive range of motion (ROM). TMA-B further included there was not a treatment to monitor skin in the palms of R3's hands.

Interview with nursing assistant (NA)-E on 2/23/16, at 7:30 a.m. indicated R3's fingers/hands had been contracted for a long time, but R3 refused to wear a splint. NA-E indicated ROM to R3's fingers/hands had not been identified as part of the plan of care, nor was monitoring and cleaning the palms of the hands, other than the weekly bath day.

Interview with NA-D on 2/23/17, at 11:42 a.m. indicated R3 had not been received any ROM nor had the plan of care included cleaning and monitoring the palms of the hands. NA-D did reveal R3 could open her hands partially if staff manually opened them.

Interview with the certified occupational therapy assistant-(COTA) clinical manager on 2/23/17, at 12:22 p.m. indicated R3's discharge instruction on 9/8/16 included recommendations by OT to discontinue the splint and for nursing staff to monitor skin and maintain skin integrity in the palm of her hand.

Interview with registered nurse (RN)-A on

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F 279	Continued From page 4 2/23/17, at 11:45 a.m. confirmed staff had not monitored nor maintained R3's skin integrity (contracted hands) per recommendations of OT. RN-A verified it had not been part of the plan of care.	F 279		
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 follow the plan of care for 1 of 3 residents (R32) reviewed for non-pressure related skin conditions. Findings include: On 2/22/17, at 12:30 p.m. R32 was observed to have a 50 cent size bruise on the top of the lower left arm. The bruise was dark purplish in color with a dark bluish colored area of bleeding that was spreading outward. Interview with R32 at this time indicated she was unable to recall how she had gotten the bruise or for how long. R32 stated " it just showed up one day". Review of R32s current plan of care identified the resident as requiring extensive assistance with ADL's. The care plan further identified R32 as being at risk for skin breakdown manifested by	F 282	We disagree with the surveyors findings in this area. We believe they are observational in nature and in no way rise to the level of a deficiency. However, in the spirit of cooperation and to ensure the highest level of care, we have taken the following steps. A treatment plan has been set up to monitor the area in question until it is resolved. In discussing this issue with staff. this appears to have been an oversight in reporting to the charge nurse. With the new computerized charting we are now using, there is an special button that reads as "report a change". Nursing assistants have been re-trained on how to use the feature to report any skin issues that they are seeing for the first time, or they have not been made aware of. This	3/23/17

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F 282	Continued From page 5 fragile skin. Interventions included to monitor skin daily with cares and report changes to the charge nurse. Review of the current physician orders indicated R32 receives Aspirin 81 milligrams (mg) daily. Interview with nursing assistant (NA)-E on 2/23/17, at 8:21 a.m. indicated she was aware of R32's bruise to the lower left arm for about a week, but did not know the reason for the bruise. NA- E indicated she had not reported the bruise to the charge nurse because she thought it had been reported. NA-B further revealed the charge nurses do monthly skin checks on the residents, to check for any skin concerns. Interview with registered nurse (RN)-A on 2/23/17, at 8:23 a.m. indicated she was not aware of R32's bruise to her left arm. RN-A further indicated the NA's should be checking residents skin daily with cares. RN-A revealed the charge nurses check for skin concerns monthly. RN-A confirmed R32's bruise had not been reported to the nursing staff when identified. Observation of R32's bruise with trained medication assistant (TMA)-B on 2/23/17, at 11:28 a.m. R32's bruise on the lower left arm remained dark purplish in color in the center with a dark bluish color extending outward. This area had the appearance of new bleeding which had spread outward underneath the skin. The bruise measured 1-1/4 inch with a 1/2 inch area of bleeding spreading outward. TMA-A confirmed she had not been aware of R32's bruise. Interview with NA-A on 2/23/17, at 11:32 a.m. indicated she had been aware of R32's bruise on	F 282	documentation automatically triggers to the charge nurse for follow up as needed. Treatments are then set up to monitor until resolved. The Director of Nursing will perform spot audits in this area to monitor continued compliance. Findings will be reported to the Quality Assurance at their quarterly meeting for analysis.	

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F 282	Continued From page 6 the lower left arm for the past week but had not reported it to the charge nurse. NA-A further stated that R32 often has evidence of bruising but was unsure how the reason. Interview with RN-A on 2/23/17, at 3:00 p.m. indicated nursing staff should have reported R32's bruise when identified so it could be investigated for possible causal factors and monitored for healing. A policy and procedure for identifying, reporting and monitoring bruises had been requested at this time, but RN-A indicated the facility did have such a policy.	F 282		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management.	F 309		3/23/17

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F 309	Continued From page 7 The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to monitor bruising for 1 of 3 residents (R32) reviewed for non-pressure related skin conditions. Findings include: On 2/22/17, at 12:30 p.m. R32 was observed to have a 50 cent size bruise on the top of the lower left arm. The bruise was dark purplish in color with a dark bluish colored area of bleeding that was spreading outward. Interview with R32 at this time indicated she was unable to recall how she had gotten the bruise or for how long. R32 stated " it just showed up one day". Review of the quarterly Minimum Data Set (MDS) assessment dated 12/23/16, identified R32 as having a Brief Interview for Mental Status (BIMS) score of "11" with cognitive loss and decline in short term memory. The MDS also indicated the resident requires extensive assistance with activities of daily living (ADL's). Review of the current plan of care identified R32	F 309	This deficiency is that same one reported in F282. Since the deficiency potentially affects two areas, we are cited twice for the same thing. As we mentioned above, we do not feel this rose to the level of a deficient practice, but we are making the following changes in the spirit of cooperation. All reported bruises are monitored until resolved. With the new computerized charting we are now using, there is an special button that reads as "report a change". Nursing assistants have been re-trained to use this feature to report any skin issues that they are seeing for the first time, or they have not been made aware of. This documentation automatically triggers to the charge nurse for follow up as needed. Treatments are then set up for skin issues to monitor until resolved. DON will audit the Report a Change documentations to ensure staff is	

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F 309	Continued From page 8 required extensive assistance with ADL's. The care plan further identified R32 as being at risk for skin breakdown manifested by fragile skin. Interventions included to monitor skin daily with cares and report changes to the charge nurse. Review of the current physician orders indicated R32 receives Aspirin 81 milligrams (mg) daily. When interviewed on 2/23/17 at 8:21 a.m., nursing assistant (NA)-E stated she had been aware of R32's bruise to the lower left arm for about a week, but did not know the reason for the bruise. NA- E stated she had not reported the bruise to the charge nurse because she thought it had already been reported. NA-B further stated the charge nurses do monthly skin checks on the residents to check for any skin concerns. During interview with registered nurse (RN)-A on 2/23/17, at 8:23 a.m. she stated she was not aware of R32's bruise to her left arm. RN-A further indicated the NA's should be checking residents' skin daily with cares. RN-A confirmed the charge nurses check for skin concerns monthly. RN-A verified R32's bruise had not been reported to the nursing staff when identified. During an observation of R32's bruise with trained medication assistant (TMA)-B on 2/23/17, at 11:28 a.m. R32's bruise on the lower left arm remained dark purplish in color in the center with a dark bluish color extending outward. This area had the appearance of new bleeding which had spread outward underneath the skin. The bruise measured 1-1/4 inch with a 1/2 inch area of bleeding spreading outward. TMA-A confirmed she had not been aware of R32's bruise.	F 309	continuing to monitor after reported. She will report her findings to the Quality Assurance committee at its quarterly meeting.	

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F 309	Continued From page 9 Interview with NA-A on 2/23/17, at 11:32 a.m. indicated she had been aware of R32's bruise on the lower left arm for the past week but had not reported it to the charge nurse. NA-A further stated that R32 often has evidence of bruising but was unsure of the reason. Interview with RN-A on 2/23/17, at 3:00 p.m. indicated nursing staff should have reported R32's bruise when identified so it could be investigated for possible causal factors and monitored for healing. A policy and procedure for identifying, reporting and monitoring bruises was requested, but RN-A indicated the facility did not have such a policy.	F 309		
F 318 SS=D	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION (c) Mobility. (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide restorative nursing programs to ensure functional range of motion (ROM) was maintained for 1 of 3 residents (R3) reviewed for ROM services.	F 318	This deficiency is the same one reported in F279. Since the deficiency potentially affects two areas, we are cited twice for the same thing. As we mentioned above, we do not feel this rose to the level of a deficient practice, but we are making the	3/23/17

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F 318	Continued From page 10 Findings include: During review of the annual Minimum Data Set (MDS) assessment dated 11/23/16, R3 was identified with impairment of range of motion (ROM) in upper extremities that included the hands and required extensive assistance in activities of daily living (ADL's). Documentation on the MDS indicated R3 did not receive occupational therapy (OT) or physical therapy (PT). Review of the annual Care Area Assessment (CAA) dated 11/23/16, identified R3 with impaired hand dexterity and functional limitation in upper extremity ROM. Review of R3's plan of care identified: extensive assistance of staff with all ADL's, experienced decreased mobility and muscle weakness and R3 attempts to feed self at times but is unable. Review of the OT plan of care dated 8/29/16 through 9/8/16, identified R3 had an evaluation for contracture prevention. R3 has a right wrist and hand orthosis (WHFO) to reduce further progressing/development and prevention of contractures but had been noncompliant with wearing the splint. The discharge notes dated 9/8/16, indicated R3 did not meet her goal with the application of the splint due to anxiety and being resistive with application. Recommendations by OT were to discontinue the splint and for nursing staff to monitor skin and maintain skin integrity in the palm of her hand. During observation and interview on 2/22/17, at 1:27 p.m. R3 had both hands clenched tightly. When the surveyor asked R3 to open her clenched hands, R3 attempted but was unable. The trained medication assistant (TMA)-B who	F 318	following changes in the spirit of cooperation. Resident #3 was re-evaluated by occupational therapy. New palm protectors were introduced to the plan of care and the resident is more accepting of this type of protector. Resident was discharged from OT with recommendations for range of motion, hygiene care, and palm protectors. The care plan has been updated to reflect these recommendations. To ensure optimal functioning of the residents of the Janesville Nursing Home a weekly Medicare meeting will include residents who have shown a decline on the MDS in mobility and functioning or possible contractures. They will be discussed for possible referrals to PT/OT for evaluation and treatment as needed. The MDS coordinator will monitor this and report findings to the Quality Assurance Committee at its quarterly meeting.	

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F 318	Continued From page 11	F 318		

was present, manually opened R3's hands, but could only open them partially before resistance was noted. R3 denied discomfort during this time. When TMA-B opened R3's right hand, the palm was whitish, moist, slightly reddened in areas and very odorous. TMA-B indicated R3 did not have a splint nor a hand protector and did not receive range of motion (ROM).

Interview with nursing assistant (NA)-E on 2/23/16, at 7:30 a.m. indicated R3's fingers/hands had been contracted for a long time, but R3 refused to wear a splint. NA-E indicated ROM to R3's fingers/hands had not been identified as part of the plan of care.

On 2/23/17, at 8:13 a.m. R3 was observed being fed breakfast by NA-F. R3 continued to have both hands clenched tightly. Interview at this time with NA-F indicated R3 at times will attempt to pick up the spoon with 2 partially open fingers of her right hand, but was unable to hold the spoon.

Interview with NA-D on 2/23/17, at 11:42 a.m. indicated R3 had not been received any ROM nor had the plan of care included cleaning and monitoring the palms of the hands. NA-D did reveal R3 could open her hands partially if staff manually opened them.

Interview with the facility certified occupational therapy assistant-(COTA) clinical manager on 2/23/17, at 12:22 p.m. indicated R3 should have received ROM services after discharge from OT on 9/8/16. The COTA confirmed the OT discharge notes should have included a recommendation for ROM to prevent further contractors of the fingers and hands. The COTA stated " it must have been overlooked" by the

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F 318	Continued From page 12 registered occupational therapist (OTR). Attempts were made to contact the facility OTR but was unsuccessful. When interviewed on 2/23/17, at 11:45 a.m. registered nurse (RN)-A, confirmed R3's care had not been implemented per OT recommendations. RN-A further included R3 should have had ROM implemented to both fingers/hands after OT services had been discontinued, to prevent further contractures and maintain ROM.	F 318		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a	F 329		3/23/17

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F 329	Continued From page 13 resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to re-evaluate the continued use of a prophylactic antibiotic medication for 1 of 5 residents (R3) reviewed for unnecessary medication. Findings include: R3 was admitted on 1/3/09 with diagnoses included: urinary tract infection (UTI) and chronic kidney disease. Review of the annual Minimum Data Set (MDS) assessment dated 11/19/16, identified R3 as frequently incontinent of urine with no toileting program, extensive assistance with toileting and receiving antibiotic treatment during the assessment period. Review of the most current plan of care identified R3 with urinary incontinence. Interventions listed were: administer daily prophylactic antibiotic for UTI prevention and monitor for side effects; check and change incontinent pads per schedule;	F 329	We disagree with the surveyors finding in this area. We feel it is an observational finding that did not rise to the level of a deficiency. However, in the spirit of cooperation, we have taken the following steps. Resident #3 was receiving Bactrim SS as a prophylactic for urinary tract infections. The physician addressed in routine rounds that medication was to be continued as it was working. Risk vs. Benefit was noted last in July 2015. The physician was notified of the findings in this area and an order was obtained to discontinue the medication and to monitor for signs/symptoms of UTI. As the facility moves forward with Antibiotic Stewardship all antibiotics orders will be reviewed for appropriateness and necessity. The consulting pharmacist will review antibiotics on a monthly basis and will	

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	245440	A. BUILDING _____ B. WING _____	02/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JANESVILLE NURSING HOME	102 EAST NORTH STREET JANESVILLE, MN 56048

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F 329	Continued From page 14 obtain urinalysis/culture as necessary; notify charge nurse of any changes in urine and encourage fluids. Review of R3's most current physician orders dated 2/22/17, included an order for Bactrim (an antibiotic) 400 milligrams (mg) /80 mg (sulfamethoxazole/trimethoprim) tablet daily (for prophylaxis of frequently occurring urinary tract infection). Review of R3's medical record indicated the resident had been receiving Bactrim since admission in 2009. Review of R3's laboratory studies in the medical record did not include any urinalysis/bladder infection studies at least in the past 2 years. Further review of R3's medical record did not include a history of UTI's nor were progress available for review which identified the need/rationale for the continued prophylactic use of the antibiotic Bactrim. There was no documentation indicating R3 had a urology consultation. Review of a consulting pharmacist recommendation for R3 dated 7/24/15, included the continued use of the prophylactic Bactrim. The pharmacist recommended the physician advise on the risk vs. benefits of Bactrim for prophylaxis, and/or if a trial discontinuation was appropriate at this time. The pharmacist further included long-term antibiotic use for UTI prevention is not advised, if avoidable. The pharmacist also identified R3 as having renal dysfunction. Review of a physician note dated 8/15/15, indicated the goal for R3 was to avoid frequent UTI's and R3 would benefit from the use of the	F 329	make recommendations to the Director of Nursing or Physician as needed. Antibiotic usage will be discussed at the quarterly Quality Assurance meeting.	

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F 329	Continued From page 15 antibiotic versus the risk of side effects. There was no further justification noted in the medical record for the continued Bactrim use nor was there a pharmacy recommendation since 7/24/15, related to the use of the Bactrim. When interviewed on 2/23/17, at 10:43 a.m. registered nurse (RN)-A indicated R3 was admitted with prophylactic Bactrim and was unsure whether R3 had been evaluated by a urologist prior to admission nor was she aware of the frequency of UTI's. RN-A indicated she could not recall the last date R3 experienced a UTI. RN-A confirmed R3 had not seen a urologist since admission and the primary physician was unaware of R3's UTI history prior to admission [2009]. RN-A confirmed the continued use of the prophylactic antibiotic should have been addressed and confirmed documentation in the medical record was lacking related to any rationale.	F 329		
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and	F 428		3/23/17

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F 428	Continued From page 16 (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility consulting pharmacist failed to address the continued use of a prophylactic antibiotic for 1 of	F 428	This deficiency comes from F329. It is the same event, but the deficiency appears in two places. As we mentioned	

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F 428	Continued From page 17 5 residents (R3) reviewed for unnecessary medication. Findings include: R3 was admitted on 1/3/09, and diagnoses included in the medical record were: urinary tract infection (UTI) and chronic kidney disease. Review of R3's most current physician orders dated 2/22/17, included an order for Bactrim (an antibiotic) 400 milligrams (mg) /80 mg (sulfamethoxazole/trimethoprim) tablet daily (for prophylaxis of frequently occurring urinary tract infection). Review of R3's medical record indicated the resident had been receiving Bactrim since admission in 2009. Review of R3's laboratory studies in the medical record did not include any urinalysis/bladder infection studies during at least the past 2 years. Further review of R3's medical record did not include a history of UTI's nor were progress notes available for review which identified the need/rationale for the continued prophylactic use of the antibiotic Bactrim. There was no documentation that R3 had a urology consultation. Review of a consulting pharmacist recommendation for R3 dated 7/24/15, included the rationale for the continued use of prophylactic Bactrim. The pharmacist recommended the physician advise on the risk vs. benefits of Bactrim for prophylaxis, and/or if a trial discontinuation was appropriate at this time. The pharmacist further included long-term antibiotic use for UTI prevention is not advised, if avoidable. The pharmacist also identified R3 as	F 428	in F329, we do not feel that this is a deficient practice but in the spirit of cooperation, we have taken the following steps. The consulting pharmacist is in building monthly to review resident charts. Resident #3 had an Physician risk vs. benefit on analysis on file for the medication in question from 7/2015 as the surveyor noted. The pharmacist states that at this time there is not a regulation to dictate the frequency that an antibiotic needs to have risk vs. benefit documented. Our team reviewed this deficiency with the physician and the medication has now been discontinued. The consulting pharmacist will continue to review antibiotics on an on going basis. She will review all findings with the Director of Nursing to ensure continued compliance in this area. All antibiotic usage will be discussed at quarterly QI meetings.	

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F 428	Continued From page 18 having renal dysfunction. Review of a physician note dated 8/15/15, indicated the goal for R3 was to avoid frequent UTI's and R3 would benefit from the use of the antibiotic versus the risk of side effects. There was no further justification noted in the medical record for continued Bactrim administration nor was a pharmacy recommendation since 7/24/15, related to the use of the Bactrim available for review. When interviewed on 2/23/17, at 10:43 a.m. registered nurse (RN)-A indicated R3 was admitted with prophylactic Bactrim and was unsure whether R3 had been evaluated by a urologist prior to admission nor was she aware of the frequency of UTI's. RN-A indicated she could not recall the last date R3 experienced a UTI while in the facility. RN-A confirmed R3 had not seen a urologist since admission and the primary physician was unaware of R3's UTI history prior to admission [2009]. RN-A confirmed the continued use of the prophylactic antibiotic should have been addressed. Interview with the director of nursing (DON) /facility consulting pharmacist on 2/23/17, at 2:30 p.m. indicated since the physician noted on 8/15/15, addressed the benefits of the prophylactic use of the Bactrim outweigh the side effects, the consulting pharmacist felt the long term antibiotic use no longer needed to be addressed. Although R3 was not exhibiting signs/symptoms of infection for at least the past 2 years (while on Bactrim) and a new diagnosis of renal dysfunction was documented, evidence was lacking to indicate the ongoing use was appropriate.	F 428		

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	245440	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/22/2017**

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K 000	**INITIAL COMMENTS** A Life Safety Code Initial Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Janesville Nursing Home) was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. The Facility is a 1 story building with a partial basement. The facility was constructed in 1965 and was determined to be of Type II (111) construction. An addition was added in 1994 and was determined to be type II (111). Both building types will be classified as one. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection, resident rooms and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 45 certified beds.	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.