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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: M4JX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00351

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245263**

2.STATE VENDOR OR MEDICAID NO.
(L2) **909545400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GLENCOE REGIONAL HEALTH SERVICES**
(L4) **1805 HENNEPIN AVENUE NORTH**
(L5) **GLENCOE, MN** (L6) **55336**

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 **10/24/2013** (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 **110** (L18)

13.Total Certified Beds **110** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	110			
(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 :
Nicolle Marx, HFE NE II — 12/16/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Shellae Dietrich, Program Specialist — 12/26/2013 (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
07/26/1983
(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
Posted 1/3/14 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/19/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN# 24-5263

On August 29, 2013 a survey was completed at this facility. The most serious deficiency was at a S/S level of J (K76-LSC deficiency). The life safety code deficiency was determined to be an immediate jeopardy, which was identified on August 28, 2013 at 4:07pm and abated on August 29, 2013 at 12pm. As a result of the survey findings we imposed State monitoring effective September 17, 2013. In addition, we recommended the following remedy for imposition:

- A Civil Money Penalty

On October 25, 2013 and November 2, 2013 the Departments of Health and Public Safety completed PCRs. Both health and life safety code deficiencies were all corrected. As a result of the revisit, we discontinued State monitoring.

In addition, we recommended the following remedy to the CMS RO for imposition and CMS concurred:

Civil Money Penalty remain in effect.

See the attached CMS-2567B forms from these revisits.

Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5263 December 26, 2013

Mr. Jon Braband, Administrator
Glencoe Regional Health Services
1805 Hennepin Avenue North
Glencoe, Minnesota 55336

Dear Mr. Braband:

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 October 1, 2013, the above facility is certified for:

110 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 110 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

December 16, 2013

Mr. Jon Braband, Administrator
Glencoe Regional Health Services
1805 Hennepin Avenue North
Glencoe, Minnesota 55336

RE: Project Number S5263022

Dear Mr. Braband:

On September 16, 2013, we informed you that the following enforcement remedy was being imposed:

- State monitoring effective September 17, 2013. (42 CFR 488.422)

On September 16, 2013, this Department recommended to the Region V Office of the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

- Civil money penalty (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for a standard survey completed on August 29, 2013. Conditions in the facility constituted immediate jeopardy to residents health and safety. The most serious deficiencies at the time of the survey were found to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required.

On October 24, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on November 2, 2013, the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to our standard survey completed on August 29, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 1, 2013. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on , as of October 1, 2013. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective October 1, 2013.

In addition, this Department is recommending to the CMS Region V Office the following actions related to the remedies outlined in our letter of September 16, 2013:

- Civil money penalty (42 CFR 488.430 through 488.444), remain in effect.

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective November 29, 2013, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective November 29, 2013, is to be rescinded.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5263r13.rtf

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245263	A. Building B. Wing	~~10/25/2013~~

Name of Facility	Street Address, City, State, Zip Code	
GLENCOE REGIONAL HEALTH SERVICES	1805 HENNEPIN AVENUE NORTH GLENCOE, MN 55336	10/24/2013 per SG & ML

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0176** Reg. # **483.10(n)** LSC	**09/23/2013**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	**09/30/2013**	ID Prefix **F0309** Reg. # **483.25** LSC	**09/23/2013**
ID Prefix **F0356** Reg. # **483.30(e)** LSC	**09/23/2013**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	**09/12/2013**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	**10/01/2013**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/SG	12/16/2013	31220	10/24/2013 ~~10/25/2013~~
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/29/2013

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245263	A. Building B. Wing **01 - MAIN BUILDING 01**	11/2/2013

Name of Facility	Street Address, City, State, Zip Code
GLENCOE REGIONAL HEALTH SERVICES	1805 HENNEPIN AVENUE NORTH GLENCOE, MN 55336

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0076	Correction Completed **08/30/2013**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** MM/PS	**Date:** 12/16/2013	**Signature of Surveyor:** 22373	**Date:** 11/02/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 8/29/2013		**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: M4JX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00351

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245263**
2.STATE VENDOR OR MEDICAID NO.
(L2) **909545400**

3. NAME AND ADDRESS OF FACILITY
(L3)
(L4) **GLENCOE REGIONAL HEALTH SERVICES 1805 HENNEPIN**
(L5) **AVENUE NORTH GLENCOE, MN** (L6) **55336**

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 **08/29/2013** (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 **110** (L18)

13.Total Certified Beds **110** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	110			
(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 :
Mary Rogers, HPR Social Work Specialist — 10/18/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 11/19/2013 (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
07/26/1983
(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
11/19/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS

At the time of the standard survey completed August 29, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 5353

September 16, 2013

Mr. Jon Braband, Administrator
Glencoe Regional Health Services
1805 Hennepin Avenue North
Glencoe, Minnesota 55336

RE: Project Number S5263022

Dear Mr. Braband:

On August 29, 2013, a standard survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Appeal Rights - the facility rights to appeal imposed remedies;

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

Potential Consequences - the consequences of not attaining substantial compliance 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.

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on August 29, 2013, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

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:

Sarah Grebenc, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301

Telephone: (320)223-7365
Fax: (320)223-7348

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective September 17, 2013. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

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.

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 remedy be imposed:

• 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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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.

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 November 29, 2013 (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 March 1, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Colleen Leach

Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure

cc: Licensing and Certification File

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245263	A. BUILDING _____ B. WING _____	08/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENCOE REGIONAL HEALTH SERVICES	1805 HENNEPIN AVENUE NORTH GLENCOE, MN 55336

(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	This plan of correction constitutes our written allegation of compliance in the area cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was sited correctly. The plan of correction is submitted to meet requirements established by state and federal law.	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to determine whether the practice of self-administration of nebulizer medications was safe for 1 of 7 residents (R76) observed for medication administration. Findings include: R76's diagnoses included chronic obstructive pulmonary disease. A significant change Minimum Data Set (MDS) dated 7/24/13, revealed the resident had no cognitive impairment. During a medication administration observation	F 176	F 176 RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE Individual resident at GRHS may self-administer drugs if the interdisciplinary team, as defined by 483.20(d)(2)(ii) has determined that this practice is safe. GRHS has included in their electronic medical record the notation of self administration of nebulizer medications. Each resident who is receiving a nebulizer medication has a 5 day trial period to assess their ability to self administer the nebulizer medication according to our standing orders. The self administration of nebulizer form is signed by resident and nurse. If during the 5 day trial period the resident has not been able to complete this process appropriately, it is discontinued and the nebulizer treatment is administered by Continued	9/23/2013

RECEIVED
SEP 30 2013
MN Dept of Health
St. Cloud

10/18/13 see addendum

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: President & CEO — (X6) DATE: 9/26/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245263	A. BUILDING _____ B. WING _____	08/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENCOE REGIONAL HEALTH SERVICES	1805 HENNEPIN AVENUE NORTH GLENCOE, MN 55336

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F 176	Continued From page 1 on 8/29/13, at 10:01 a.m. licensed practical nurse (LPN)-C prepared and applied a nebulizer treatment mask to R76. LPN-C then told R76 that she would return in ten minutes, when the treatment was complete. LPN-C exited R76's room and proceeded down the hallway to the nurses' station. LPN-C then stated she needed to take a break and trained medication aide (TMA)-A would administer the second nebulizer treatment to R76. TMA-A returned to R76's room at 10:25 a.m. TMA-A initiated the nebulizer treatment, applied the mask to R76 and then asked R76 if she should stay. R76 replied, "No, I can take the mask off when I am finished." TMA-A left the room and returned to the nurses' station. When asked if R76 had a physician's order to indicate self-administration of medications was safe, TMA-A stated R76 did not have an order. During an interview on 8/29/13, at 11:53 a.m. assistant director of nursing (ADON) indicated if a resident wanted to self-administer medications a five day trial process was initiated to determine whether the practice was safe for the resident and then a physician's order was obtained. ADON verified R76 had not been assessed for safety with self-administration of medications and a physician's order was not obtained. R76's medical record revealed no assessment, physician order, or care plan provision for self-administration of medication. Review of the Self Administration of Meds (Medications) policy revised on 11/3/08, revealed residents had the right to self-administer medications if the facility's interdisciplinary team	F 176	staff. If the resident was successful in safe administration during the 5 day assessment period, it is written on the round the world sheet and brought to the multidisciplinary team which meets each morning. If the entire team feels it is safe to self administer the medication, the charge nurse obtains the physician order and the resident is then allowed to self administer the nebulizer medication. Resident #76: Was given a 5 day trial period of self administering nebulizer medication; 9-2-13 through 9- 9-13. This was subsequently reviewed by staff on 9-10-13. All interdisciplinary departments were in agreement that resident could self administer nebulizer medications. Charge nurse notified resident's physician of this decision. Order was obtained on 9-12-13 from resident's physician for resident to self administer nebulizer medications after nurse sets up. On 9-3-13 all licensed staff was re-educated on the process of a 5 day trial before self administering nebulizer medications according to our standing order, then put it on the round the world sheet to be addressed at morning report, and if approved the charge nurse will then get the MD order. The nurse inputting the self administration nebulizer order is responsible to ensure that the 5 day trial of Continued	

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F 176	Continued From page 2 and their physician had determined the practice was safe.	F 176	self administration occurred successfully. The RN's are to check each neb order for self administration when they complete their monthly med reviews. DON/ADON will quarterly monitor all residents on nebs during case management to assure appropriate documentation is present for self administration of nebs when appropriate	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each resident's private space was respected by facility staff knocking on residents' doors and requesting permission to enter and closing doors when requested, for 5 of 5 residents (R74, R59, R79, R92 and R127) reviewed for dignity. Findings include: R74 was interviewed and observed on 8/26/13, at 4:32 p.m. R74 was interviewed in her room, with the door to the hallway closed for privacy. During the interview, helper (H)-A opened R74's door and proceeded into the room carrying a pitcher of water. She picked up the old pitcher from the bedside table, replaced it with a fresh pitcher, smiled at R74, exited the room and closed the door behind her. H-A did not knock on R74's door to announce her presence, nor did she request permission to enter the room. H-A did not verbalize any communication to R74 throughout the observation. Trained medication aide (TMA)-C was then noted to knock on R74's door and entered the room as he knocked,	F241	F241 DIGNITY AND RESPECT OF INDIVIDUALITY GRHS does promote care of residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. The DON will assure that a mandatory Respect and Dignity Quiz will be given to all LTC employees (including the LTC helpers, Dietary Staff, Housekeeping, laundry, and Maintenance) by September 30th. This will include the requirement of knocking on a resident's door and asking permission to enter, EVEN if the door is open and upon re-entry. Continued	9/30/2013

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F 241	Continued From page 3 without waiting for permission to enter. He offered to assist R74 to the dining room for supper upon completion of her interview, then exited the room without closing the door behind him. R74 was asked whether the facility employees typically knocked before entering her room. She responded, "No, they just come in like they own the place." R74 added that she would have preferred the employees knocked before they came in and shut the door when they left. She added, "That's one thing I wish they did." When TMA-C returned to the room upon completion of the interview, R74 teased TMA-C about forgetting to close her door and said, "What, were you born in a barn?" A note was observed to be posted on R74's door to the hallway, that instructed to keep her door closed. R59 and R79 shared a room and R92 and R127 shared a room. During an observation on 8/28/13, at 8:30 a.m. nursing assistant (NA)-B entered R59 and R79's without knocking or announcing herself prior to entering the room. Both R59 and R79 were present in the room at the time of this observation. NA-B then exited the room to get a wheelchair from the hall and re-entered, again without announcing herself or knocking. At 8:34 a.m., NA-B entered room R92 and R127's room without knocking or announcing herself. Both R92 and R127 were present in the room at the time of this observation. At 8:38 a.m., NA-B exited room the room with an EZ stand (a lift used for transfers) and again entered room R59 and R79's room without knocking or announcing herself. At 8:42 a.m., NA-B exited the room and re-entered the same room after retrieving items from the laundry cart. NA-B again entered room	F 241	On 9-3-13 LTC nurses meeting, additional education was provided on making sure ALL staff understands the importance of knocking on doors and asking permission to come in. Staff are completing observations of other staff to monitor compliance with knocking on doors. These observations are being completed on all 5 wings each week x 6 weeks. DON/ADON is checking with each of the following residents resident #74, #59, #79, #92, and #127 once a week x 6 weeks to assure that staff is knocking and asking permission to enter their room. All residents are in agreement that this is being done at this time. Resident #74 at her request has a note on the outside of her door requesting that her door be kept shut at all times. DON will do random audits to assure that staff continues to knock on the doors and request permission to enter each resident room. This will become a routine question every 2 months at resident council.	

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F 241	Continued From page 4 R59 and R79's room without knocking or announcing herself. NA-C was interviewed on 8/29/13, at 3:18 p.m. and verified the nursing assistants received annual training on dignity concerns including knocking on resident doors before the staff enter the room. During an interview on 8/29/13, at 3:25 p.m. assistant director of nursing (ADON) verified it was her expectation for employees to knock on a resident's door and call out to them, requesting permission to enter. She reported that dignified care and services was covered in an online annual training provided to all employees. ADON reported the facility did not have a policy related to provision of dignified care and services.	F 241		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to note, internally report, assess, treat, monitor and document bruises of unknown origin for 2 of 3 residents (R33 and R121) reviewed for non-pressure related skin issues.	F 309	F 309 PROVIDE CARE/SERVICES FOR HIGHEST WELLBEING Each resident will receive and GRHS will provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. Continued	9/23/2013

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F 309	Continued From page 5 Findings include: R33 was observed on 8/27/13, at 10:01 a.m. to have multiple bruises on the forearms. The quarterly Minimum Data Set (MDS) dated 6/19/13, identified R33 was severely cognitively impaired. R33 required extensive assist of two staff for bed mobility, dressing, toileting and grooming. Limited assistance was needed for transferring and supervision during locomotion and off the unit. A day shift care card (a form which gave direction to the nursing assistants) last updated on 8/27/13, did not identify any skin concerns. The evening care card last updated on 8/20/13, also did not identify any skin concerns for R33. The care plan dated 3/19/13, indicated R33 was at risk for skin breakdown and had interventions of skin checks with cares by the nursing assistant (NA), to report changes to the nurse and nurses were to complete skin assessments per policy. During an interview on 8/28/13, at 2:07 p.m., licensed practical nurse (LPN)-B indicated the NA's would report bruising to the licensed staff who would then let the charge nurse know. The findings would be entered on a skin incident form in the electronic record and added to the treatment administration record (TAR) to be monitored daily until resolved. LPN-B further stated the NA's would find any changes in skin integrity daily with cares and during resident baths. LPN-B identified R33's bath days were Tuesday evenings and Saturday mornings. (R33's last bath would have been the evening	F 309	Skin assessments will be done on admission, readmission, significant changes, quarterly, and on an as needed basis for non-pressure related skin issues. NAR's will do a daily skin inspection when dressing/undressing, bathing, toileting, and when providing incontinence care or as any skin change is noted IE: bruise, skin tear, etc. A skin incident report form will be completed on any new identified skin issue to include cause of injury, treatment to injury, interventions to prevent injuries. Physician and families will be notified of any skin incident. On 9-3-12 education was provided to the licensed staff on comprehensive skin assessments and how to get the documentation into the electronic medical record so that it triggers on the MAR/TAR to check daily and chart weekly until resolved. We completed the skin assessments on the two residents (R33 and R121) with their bruises now being monitored daily and charted weekly. Continued	

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F 309	Continued From page 6 prior to the interview with LPN-B) LPN-B stated she had noticed some bruising on R33's arms, and after a review of the chart stated, "I know now that we aren't monitoring them, so I will go in and make a report about them." R121 was observed on 8/26/13, at 2:05 p.m. to have multiple bruises at various stages of healing on both forearms. R121 could not explain what had caused the bruising. The admission MDS dated 5/28/13, identified R121 was cognitively intact. R121 required extensive assist of one staff for bed mobility, dressing, toileting, grooming and transfer assistance. R121's current day and evening shift care cards did not have any skin concerns noted. During an interview on 8/28/13, at 2:18 p.m., TMA-A checked R121's clinical record for skin monitoring. TMA-A did not find anything in the record which indicated staff were monitoring bruising. TMA-A stated R121 self-transferred a lot and bummed his arms frequently which may have caused the bruises, "But that is just speculation." The care plan identified R121 was at risk for skin breakdown and had interventions of skin checks with cares by NA, to report changes to the nurse and nurses were to complete skin assessments per policy. During an interview on 8/29/13, at 8:40 a.m., NA-A stated she would report any skin concerns to the nurses who would then do skin checks but wasn't sure how often. When asked if R121 currently had any bruises, NA-A replied that she	F 309	We educated the NAR's by providing them with a list of skin items they must observe and report. The electronic medical record now has a red button "Observe Closely" which appears when a skin condition is observed. This will flag the NAR's to watch that area closely for 3 days, send a warning to the wing nurses, and send a warning to the DON/ADON. A copy of the issues to report was reviewed at the Mandatory Staff meeting on 9-25-13. Resident 33 is still being monitored daily and charted weekly as the bruises are not quite healed as of 9-23-13 Resident 121 is still being monitored daily and charted weekly as the bruises are not quite healed as of 9-23-13 The ADON performs wound rounds weekly. She will discuss all skin changes with the wing nurses on each wing to assure that all skin changes are being monitored daily and charted on weekly.	9-23-2013

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F 309	Continued From page 7 thought so, "On the arms." During an interview on 8/29/13, at 11:30 a.m., assistant director of nursing (ADON) indicated skin incident forms should be completed for any wound on residents. ADON stated she was aware of the bruising on R33's arms but had thought it was discoloration due to old age and that they had always been there. ADON stated, "We talked about his skin this week because he had that fall, and bruising was expected." ADON reviewed the admission skin assessment which indicated R33 did have bruising when admitted, but the skin assessment forms which had monitored the bruises weekly indicated they had healed. ADON confirmed there were no current skin incident forms or monitoring in place related to R33's arms. ADON then reviewed the medical record for R121 and revealed there had been a rash on the arms, "A while back" but confirmed there was nothing on the TAR which indicated staff were currently monitoring any bruises. Review of the Skin Integrity Universal Guidelines policy (no date) indicated staff would assess, intervene, and treat impairment of skin integrity according to the Pressure Ulcer and Associated Skin Policy. Review of the Pressure Ulcer Skin Risks policy revised 9/12, revealed all individuals at risk should have a systematic skin inspection at least once a day. The NA's would provide the inspection when doing AM and PM cares and during the weekly bath. Any findings would be reported to the wing nurse and ADON. It would then be added to the TAR to be checked daily and charted on weekly.	F 309		

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F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to post required staffing information as required. This practice had the potential to affect all 102 residents residing in the	F 356	F356 POSTED NURSE STAFFING INFORMATION GRHS will post the following information on a daily basis: • Facility name • The Current date • The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: o Registered nurses o Licensed practical nurses or licensed vocational nurses (as defined under State law) o Certified nurse aides • Resident Census. GRHS will post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data will be posted as follows: o Clear and readable format o In a prominent place readily accessible to residents and visitors. The facility will, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. Continued	9/23/2013

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F 356	Continued From page 9 facility as well as visitors. Findings include: During initial tour on 8/26/13, at 10:30 a.m. the nurse staffing posting was reviewed. The form did not identify the actual or total hours worked for registered nurses, licensed practical nurses or nursing assistants. During interview on 8/27/13, at 3:30 p.m. trained medication aid (TMA)-B verified she was the person that was responsible to create the nurse staff posting. TMA-B indicated she just filled in the boxes to show how many licensed and unlicensed staff worked and what the total full time equivalent (FTE) was for each. TMA-B was not aware of any other information which was required to be on the posting. A policy was requested, however none was provided.	F 356	The facility will maintain the posted daily nurse staffing data for a minimum of 18 months,or as required by State law, whichever is greater. The DON/ADON will be responsible for monitoring to see that these are appropriately posted.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation review the facility failed to store and prepare food items under sanitary conditions, related to the cleaning of kitchen equipment, the	F 371	F 371FOOD PROCURE,STORE/PREPARE/ SERVE• SANITARY GRHS will: 1. Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and 2. Store, prepare, distribute and serve food under sanitary conditions. The vent hood over the grill area was noted to have grease particles on it. The GRHS maintenance staff will clean the vent hood covers monthly and the entire vent hood system will be cleaned every 6 months by a Continued	9/12/2013 9/24/2013

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F 371	Continued From page 10 labeling and dating of opened liquids and food items in the refrigerators, ensuring the garbage remained covered and maintained, and ensuring safe temperatures for food service. This had the potential to effect all 102 of 102 residents who ate in the facility. Findings include: On 8/26/14, at 10:15 a.m. during a tour of the kitchen, with the director of nutritional services, the baking storage room revealed the vent hood over the grill area to have grease particles on it. The cooler contained eight thawed 4 ounce (oz.) containers of vanilla mighty shake with no date when they were removed from freezer to thaw. The pastry cooler contained a bowl of whipped cream with plastic wrap over it with no date that it was made. The director of nutrition services confirmed there was no date written on it. The baking storage area contained two open 16 oz. bags of marshmallows with no date written on them when they were open. The director of nutrition services confirmed that there was no date written on the packages of when they were opened. The nourishment center refrigerator contained a 46 oz. container of apple juice that was half full with no date that it was opened. During a tour of the kitchen on 8/29/13, at 11:10 a.m. an uncovered garbage can was placed by the food preparation. The garbage can was observed to overflow and debris was observed on the food preparation floor. The dietary manager (CDM) was present and reported it was unacceptable for the garbage to be uncovered in the food preparation area and placed a lid with a hole on the top on the garbage can. She further stated when dietary staff are actively preparing the food, it would be acceptable not to have the lid on the garbage can but as food preparation	F 371	professional steam cleaning company (Enviromatic). The Director of Maintenance will monitor this on a monthly basis, or as needed as identified by the dietary staff. Dietary staff education regarding safe food storage, appropriate labeling, and dating of open food items in all storage areas was completed on 9-11-13. The safe food storage policy was reviewed with the staff. A competency test was given to each dietary staff member to ensure knowledge of safe food storage standards on 9-11-13. Routine follow-up will occur 4 x weekly by the Food Service Supervisor when ordering and receiving food products. This audit will be carried out for 6 weeks and the audit log will be reviewed weekly by the Director of Nutrition Services. Garbage cans are to be covered when not in use and dirty dishes will be left in designated areas when unattended. All dietary staff members were educated on the importance of maintaining sanitary work environments at the 9-11-13 dietary staff meeting. A form was made and posted Continued	9/12/2013

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	245263	A. BUILDING _____ B. WING _____	08/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENCOE REGIONAL HEALTH SERVICES	1805 HENNEPIN AVENUE NORTH GLENCOE, MN 55336

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F 371	Continued From page 11 was not occurring, it should be covered. A large industrial metal mixing bowl and mixer blades were observed stored in the dry food storage area, during the tour. The CDM reported it was not acceptable to store dirty dishes in the clean storage room. An interview with dietary aid (DA)-A was completed on 8/29/13, at 11:20 a.m. She acknowledged she had baked earlier in the day and the dirty dishes in the clean storage area were the ones she had used. She indicated she did not know how the dirty dishes got into the clean storage area. DA-A reported the dirty dishes should have never been put in the clean storage area. Meal service was observed in the Sunshine dining room on 8/29/13, at 12:10 p.m. with DA-B serving the meal. DA-B reported she had obtained the temperature of the food items at 11:45 a.m. and the all the food items were within the accepted temperature range, other than the lettuce/cheese/tomato mixture. She indicated this mixture was at a temperature of 51 degrees and it should have been less than 40 degrees. She reported she put the mixture into the refrigerator in efforts to cool the mixture but at serving time, it was still too warm. DA-B reported that she should have taken the food mixture to the kitchen and exchanged it for a mixture that was the correct temperature. She indicated the residents were waiting for their lunch and so as to not make them wait, she served the food at the improper temperature. This was verified by the CDM, who was present during the interview. The facility's Food Safety-Holding and Serving policy, dated 1/13, directed staff to hold potentially hazardous cold food at 41 degrees or less. It	F 371	on the dietary bulletin board in the kitchen. One staff member is assigned at each break time to ensure compliance with the covering of garbage cans not in use and the appropriate storage of dirty dishes by signing his/her initials on the form. This process ensures a check for compliance 8x daily by cooks and dietary aides. The Director of Nutrition Services/Food Service Supervisor will formally follow-up 1x weekly through October by reviewing the initialed form and will routinely monitor sanitary work stations in the kitchen at non-production and production times. Food will be held and served at proper safe temperatures. On 9-11/13, dietary staff were re-educated on safe food holding and serving temperatures. A new temperature log was created and implemented. The Director of Nutrition Services will follow up daily through the month of September to ensure compliance. Further education will be carried out on a one-to-one basis with employees as deemed necessary Continued	9/11/2013

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F 371	Continued From page 12 also directed staff to take and record all cold items served at each meal and out of range temperatures will be reported to the cook on duty. The policy added, refrigerated food items were to be labeled, dated, and monitored on a daily basis and opened packages were to be labeled with date of original use.	F 371	by the Director of Nutrition Services. After September, monthly log checks will be completed by the Director of Nutrition Services to ensure ongoing compliance.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 431	F 431DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS GRHS will employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation;and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biological used at GRHS will be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions,and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biological in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. Continued	10/1/2013

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F 431	Continued From page 13 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 store and maintain medications for 4 residents (R99, R81, R98, and R78) during review of five medication carts. The facility also failed to ensure medications remained locked and inaccessible to unattended residents, for 1 of 1 resident (R132) observed during a medication pass. Findings included: Five medication carts were reviewed on 8/28/13, at 2:30 p.m. and four medications were found expired. Artificial tears, ordered for R99 had expired on 1/13/13. Brimonidine 0.2% Solution (medication eye drops), ordered for R81, had expired on 1/16/13. Bethamethasone 0.05% (medicated cream), ordered for R98, had expired 4/13 and Triamcindol 0.1% (medicated ointment), ordered for R78 had expired on 5/22/13. All of these medications were available for use. An interview was conducted with registered nurse (RN)-A on 8/28/13, at 2:30 p.m. She reported staff, who administer medications, are to check the expiration dates of the medications on a daily basis. The facility's policies Medication Administration, reviewed 1/13 and Storage of Medications, last reviewed on 9/26/09, did not address monitoring	F 431	GRHS will 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. GRHS has added a policy and procedure regarding assessing for expired meds. A form has been added to the night nurses responsibilities for checking all 5 med carts twice a month to assure that all expired meds have been removed/replaced at the time of expiration. All meds in the med cart are to be only the meds currently being used and not expired. Resident #99 has a new prescription and the expired med has been removed. Resident# 81 has a new prescription and the expired med has been removed. Resident #98 has a new prescription and the expired med has been removed. Resident #78 has the med discontinued and it has been removed. Continued	

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F 431	Continued From page 14 for expiration of medications. Medications were left unlocked and unattended during a medication pass. R132 was observed to sit in a Broda chair (tilt and recline positioning chair) outside the courtyard dining room on 8/28/13, at 10:05 a.m. Licensed practical nurse (LPN)-A walked away from the medication cart to another resident's room and while a box of Lidoderm 5% patches (an adhesive material containing 5% lidocaine) remained on the table next to the medication cart. An interview on 8/28/13, at 10:08 a.m. with was conducted with LPN-A who acknowledged the Lidoderm 5% patches should not have been left on the table next to the medication cart while LPN-A went to another resident's room. An interview on 8/29/13, at 8:57 a.m. was conducted with the assistant director of nursing (ADON) who also acknowledged the LPN should not have left the medication on the table while the LPN went to another resident's room. The medication administration policy (revision date 1/2013) identified medication carts are to be locked at all times when not being used to dispense medication; unless nurse has direct observation of the cart.	F 431	The charge nurse on nights is responsible for making sure the log is completed every other Tuesday on each of the 5 wings. The night charge nurse will provide a copy of the log Quarterly to the DON to assure that meds are consistently being checked and that expired meds are removed from the med carts. GRHS policy is that all medication carts are to be locked at all times when not being used; unless the nurse has direct observation of the cart. Education was completed on 9-3-13 to all LTC nursing staff regarding the policy that medications are NEVER to be left unattended and medication carts are to be locked when not in immediate observation by a nurse. A medication audit sheet has been developed and will be completed on all three shifts by the charge nurse for one month, verifying that no meds are left unattended and carts are locked at all times when no one is present. This audit tool will be shared with all nurses. The DON/ADON will complete random audits to assure that medications remain locked and safe, in accordance with facility policy.	10/1/2013

Glencoe Regional Health Services

Hospital & Long Term Care
1805 Hennepin Ave. N.
Glencoe, MN 55336-1416
320.864.3121
1.888.526.4242
Fax: 320.864.7887

Glencoe Clinic
1805 Hennepin Ave. N.
Glencoe, MN 55336-1416
320.864.3121
1.888.526.4242
Fax: 320.864.7998

Lester Prairie Clinic
1024 Central Ave.
Lester Prairie, MN 55354-4525
320.395.2527
Fax: 320.395.2528

Stewart Clinic
300 Bowman St., Box 256
Stewart, MN 55385-0256
320.562.2558
Fax: 320.562.2559

October 18, 2013

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

RE: Addendum to Plan of Correction for Glencoe Regional Health Services
Provider ID #: 245263

This letter serves as an addendum to the Plan of Correction submitted by Glencoe Regional Health Services on 9/26/2013.

Monitoring results will be brought to the Quality Improvement Committee for compliance oversight and recommendations. Monitoring will include the following:

- Review of random audits of staff and observation, and audits of resident feedback regarding respect and dignity issues, including staff knocking before entering resident rooms.
- Review of process to post daily nursing staff hours.
- Review of dietary audit logs.
- Review of expired medication audit logs.
- Review of locked med carts/no unattended medications audits.

Jon D. Braband
President & CEO

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

F 5263021

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K 000	INITIAL COMMENTS	K 000		

D.C. 10.08.2013

FIRE SAFETY

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 FORM-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.

POC ok
TB 10-23-13

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.

Exit: 08/29/2013

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on August 29, 2013. At the time of this survey, Glencoe Regional Health Services C & NC was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
444 Cedar St., Suite 145
St Paul, MN 55101-5145, or

RECEIVED
OCT 1 2013
MN DEPT OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	President & CEO	9/27/2013

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

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K 000	Continued From page 1	K 000		

By email to:
Barbara.Lundberg@state.mn.us and,
Marian.Whitney@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Glencoe Regional Health Services C & NC was constructed as follows:
The original building was constructed in 1984, it is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type I(332) construction;
A building addition was constructed in 1995, it is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type I(332) construction.

The facility has a complete automatic 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 is separated from both a hospital and a senior apartment building, by 2-hour fire wall assemblies, with opening protectives consisting of labeled, self-closing, positive latching, 90-minute fire-rated door assemblies. The facility has a capacity of 110 beds and had a census of

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K 000	Continued From page 2 103 at time of the survey. Because the original building and the one addition met the construction type allowed for existing buildings, the facility was surveyed as one building, and one (1) Form CMS-2786R booklet was completed. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 076 SS=J	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to administer oxygen in accordance with NFPA 99 (1999 edition) Chapter 4, Section 4-3.5.2, Chapter 7, Section 7-2.1, Chapter 8, Sections 8-2.1.2.4(d), 8-3.1.11 and 8-6.2.1. This deficient practice potentially affected 3 of 110 residents. FINDINGS INCLUDE:	K 076	KTag076 Medical Gases and Anesthetizing Areas Medical gas storage and administratron areas shall be protected in accordance with NFPA Standard 99 (1999 edition.) GRHS has developed and implemented written policies and procedures that prohibit oxygen use within the beauty shop area. Any resident requiring continuous oxygen will require a physician order to authorize removal of oxygen while in the beauty shop. Any resident who cannot go without oxygen will have their hair washed and set in their room and allowed to air dry. Signs are posted in the beauty shop stating NO OXYGEN use. Continued	~~8/29/2013~~ 8-30-13

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K 076	Continued From page 3 On 08/28/2013 at 10:00 AM, while on-survey in The Beauty Shop, staff from the Minnesota Department of Health (MDH) survey team observed one (1) nursing home resident seated below a bonnet-type, floor standing hair dryer. The resident was receiving oxygen therapy, delivered via nasal cannula, while the facility's Beautician was utilizing an electric curling iron on the resident's hair. It was further observed that the floor standing hair dryer was equipped with an electric receptacle, which could be used to energize other portable electrical appliances. Both the electric curling iron in-use, and the receptacle, were located within 12- inches from the oxygen's point of intentional expulsion, i.e., nasal cannula, and within the oxygen enriched atmosphere. As such, the possibility of an electric spark-induced fire originating from either the curling iron or the electric receptacle existed, with actual or potential for serious injury, impairment or death. Therefore, on 08/28/2013 at 4:07 PM, the MDH survey team did call a K076 deficiency at Scope and Severity level Immediate Jeopardy. On 08/29/2013 at 12:00 PM, the facility submitted a Plan of Correction for this K076 deficiency, which was accepted by the deputy state fire marshal on-site, with verbal confirmation via telephone by the Minnesota State Fire Marshal Division (SFMD) Fire Safety Supervisor for Healthcare, and the Immediate Jeopardy was lifted. The facility will submit their Plan of Correction with supporting documentation along with Form CMS 2567.	K 076	This area will be monitored while in use by the Director of Activities/activity designee for ongoing compliance. Education was provided one-on-one by the Activity Director to beauticians/barbers on the new policy of no oxygen and use of the pull cord. The call light has been changed in the beauty shop to a pull cord. The Activity Director/activity designee will monitor for compliance for 3 months to assure the policy is being enforced. The Activity Director will do random assessments to assure ongoing compliance.	