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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: M5JZ

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

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/19/2012** (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 IMR**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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	IMR
	89			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Marge Meeker, Unit Supervisor 03/20/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Susan N. Leppke, Program Specialist 03/20/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 4/6/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/16/2012
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

At the time of the standard survey completed on February 2, 2012, the facility was not in substantial compliance and the most serious deficiencies were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections were required. The facility was given an opportunity to correct before remedies were imposed.

On March 19, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on March 5, 2012 the Minnesota Department of Public Safety completed a PCR by review of the plan of correction and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 2, 2012, effective March 19, 2012. Therefore remedies outlined in our letter dated February 14, 2012, will not be imposed. See the attached 2567-b forms for the results of the March 19 and March 5, 2012 revisits.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 20, 2012 CMS Certification Number (CCN): 245325

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

Dear Mr. Oelrich:

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 19, 2012 the above facility is recommended for:

89 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Susan N. Leppke

Susan N. Leppke, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4121 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 20, 2012

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

RE: Project Number S5325021

Dear Mr. Oelrich:

On February 14, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 2, 2012. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On March 19, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on March 5, 2012 the Minnesota Department of Public Safety completed a 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 2, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 19, 2012. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 2, 2012, effective March 19, 2012 and therefore remedies outlined in our letter to you dated February 14, 2012, 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.

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

Feel free to contact me if you have questions.

Sincerely,

Marge Meeker

Marge Meeker, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (320) 223-7317 Fax: (320) 223-7348

Enclosure

cc: Licensing and Certification File 5325r12.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
245325	A. Building B. Wing	3/19/2012

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0166** Reg. # **483.10(f)(2)** LSC	Correction Completed **03/19/2012**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **03/19/2012**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **03/19/2012**
ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **03/19/2012**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **03/19/2012**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **03/19/2012**
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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/SNL	03/20/2012	~~20012~~ 03020	03/19/2012
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 2/2/2012

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245325	A. Building B. Wing 01 - MAIN BUILDING 01	3/5/2012

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0029	Correction Completed 02/02/2012	ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 02/02/2012	ID Prefix Reg. # NFPA 101 LSC K0069	Correction Completed 02/02/2012
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	Date:	Signature of Surveyor:	Date:
	SNL/PS	03/20/2012	27200	03/05/2012
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
2/1/2012	

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 A. Building B. Wing	(Y3) Date of Revisit
245325	02 - 2008 ADDITIONS	3/5/2012

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0062	02/02/2012	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		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By SNL/PS	Date: 03/20/2012	Signature of Surveyor: 27200	Date: 03/05/2012
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 2/1/2012		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: M5JZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00629

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

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

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

4. TYPE OF ACTION: **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 **02/02/2012** (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 IMR	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Mary Rogers, HFE NE II 03/05/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Susan N. Leppke, Program Specialist 03/08/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 3/16/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

At the time of the standard survey completed on February 2, 2012, the facility was not in substantial compliance and the most serious deficiencies were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3051 4877

February 14, 2012

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

RE: Project Number S5325021

Dear Mr. Oelrich:

On February 2, 2012, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Marge Meeker
Minnesota Department of Health
3333 West Division Street, Suite 212
St. Cloud, Minnesota 56301-4557

Telephone: (320) 223-7317

Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 13, 2012, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 13, 2012 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

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 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 2, 2012 (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 2, 2012 (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,

Marge Meeker

Marge Meeker, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (320) 223-7317 Fax: (320) 223-7348

Enclosure

cc: Licensing and Certification File 5325s12.rtf

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
	245325	A. BUILDING _____ B. WING _____	02/02/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. 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 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to promptly investigate and resolve grievances related to reported missing personal property for 1 of 1 resident (R75) reviewed for missing personal property. Findings include: R75 had multiple diagnoses that included Alzheimer's disease and dementia without behaviors. During interview at 8:30 a.m. on 1/31/12 R75's family (Family-A) reported he was missing a watch. Family-A stated she reported this	F 166	See Attached POC MM Dates of completion are All 3/13/2012 ok'd 3/5/12 mm	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 2/27/12

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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F 166	Continued From page 1 information to the nursing staff approximately two days prior and no one had followed-up with her. During interview at 3:54 p.m. on 1/31/12 registered nurse (RN)-D stated she was not aware R75 had any missing personal items. During interview at 3:55 p.m. on 1/31/12 clinical manager (CM)-A stated the facility's process for reported missing personal items was to fill out a concerns report, then give the report to the social worker, who then alerted the department heads. CM-A stated the social worker was then to follow up with the resident/family involved. CM-A stated she was not sure if R75 had any missing property. When cued if Family-A reported a missing watch, CM-A stated, "Oh yeah that's right." CM-A revealed that Family-A had reported the missing watch about two weeks prior and nursing filled out a concern form. A copy of the form was requested at this time. However, the facility was unable to provide evidence that a concern form was filled out for R75's missing watch. During interview at 1:56 p.m. on 2/1/12, licensed social worker (LSW) stated the facility's process was to fill out a missing items report for reported missing personal items, pass the information on to LSW and the director of nursing (DON). LSW stated he was responsible for following-up with the resident and family. LSW confirmed he was not aware of R75's missing watch until yesterday when CM-A brought it to his attention. LSW stated he would expect this was passed on to him when Family-A reported it two weeks prior. During follow-up interview at 10:00 a.m. on	F 166		

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F 166	Continued From page 2 2/2/12, CM-A confirmed the facility did not follow their procedure for investigating missing personal items. The facility's Concern and Missing Item Policy instructed staff to conduct a search among the parties involved and complete a concern and resolution report or missing item report. The policy added that the concern and resolution report should be handed to the social service department. The policy indicated if the initial search was ineffective the missing item report should be given to the social worker and a copy should be placed on the communication board to notify staff of missing item. This process was not followed for R75.	F 166		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		

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F 280	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure each resident's plan of care was updated as necessary to meet the needs of the resident, related to significant weight loss for 1 of 3 residents (R63) reviewed in the sample for weight loss, and related to oral care for 1 of 4 residents (R62) in the sample reviewed for activities of daily living. Findings include: The facility did not revise R63's plan of care to include interventions to address significant weight loss. R63 diagnoses included dyspnea (shortness of breath), chronic kidney disease, prostate cancer, weakness, osteoporosis, esophageal reflux, anxiety and depression. The admission minimum data set (MDS) dated 11/29/11 revealed R63 had moderately impaired cognition and was independent with set-up for eating. The care area assessment (CAA) dated 11/29/11 identified R63 was on a low sodium diet with regular consistency, ate independently, consumed 76-100% of his meals and had no chewing or swallowing problems. R63's weight was noted as 206 pounds. Review of the plan of care dated 12/6/11, identified R63 was at risk for altered eating status due to his diagnoses. Interventions included a	F 280		

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F 280	Continued From page 4 low sodium diet with regular consistency, eating meals in the dining room, honoring R63's preferences and receipt of a daily multivitamin. Review of weekly vital flow sheets revealed R63's weight on 12/11/11 was 204 pounds and his weight on 1/9/12 was 190 pounds. This was a significant weight loss of 7.8% in one month. R63's most recent weight taken on 1/24/12 was noted as 186 pounds. Review of physician orders dated 1/30/12 indicated R63 was not prescribed a nutritional supplement and was not on a prescribed weight loss program. Review of the medication administration record (MAR) dated 1/1/12 to 1/31/12 revealed R63 did not receive a nutritional supplement. During interview at 12:47 p.m. on 2/1/12, registered nurse (RN)-A verified she had not been informed of R63's weight loss until 1/31/12. During interview at 1:45 p.m. on 2/1/12, certified dietary manager (CDM) reported that she identified R63 had weight loss during the first week of January when she reviewed his weights in preparation for an assessment. CDM stated that when she identified the weight loss, she reported it to RN-B, but RN-B had since ended her employment with the facility. CDM reported she was unaware that RN-A had not been informed of the weight loss until 1/31/12. During follow-up interview at 9:49 a.m. on 2/2/12, CDM added that upon identifying R63's weight loss, she talked to R63 and discovered he had a "poor appetite." CDM reported that she informed	F 280		

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F 280	Continued From page 5	F 280		

registered dietician (RD) when she visited the facility "last week" that R63 had experienced weight loss. At 1:45 p.m. on 2/2/12, CDM added that she had informed the facility's nursing department of R63's poor appetite at the time she identified his weight loss. CDM verified that intake records were not initiated for R63, but added that it was the responsibility of the nursing department to initiate recording of a resident's intake.

During interview at 2:00 p.m. on 2/2/12, director of nursing (DON) described the facility policies and procedures related to weight loss. DON reported that NAs weighed each resident weekly during their baths and were expected to re-weigh a resident if there was a five pound weight loss or gain. The weights were then to be recorded in the MAR. DON verified the LPNs were then responsible for reviewing the weights recorded and reporting concerns to the RNs. DON verified there were no records of R63's intake, evidence of interdisciplinary discussion or evidence of interventions added to the plan of care for R63's weight loss since it was initially discovered by the CDM on 1/9/12, until 1/31/12.

During interview at 2:30 p.m. on 2/2/12, RD verified that if a referral had been made for R63 to be seen, there would have been notes indicating the referral and the follow-up in the medical record. RD verified that "typical practice" was for weight loss to be addressed by the RN's and then for a referral to be made to RD. Upon brief review of R63's record, RD reported that she would "typically" have expected interventions be put into place by the facility's nursing department and a referral for R63 to be seen by RD during

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F 280	Continued From page 6 her monthly visit to the facility. R62's care plan was not revised to reflect a dental consult recommendation to increase oral hygiene. According to a facility Consult Form dated 11/2/11, the resident was seen by the dentist for restoration of some decayed teeth. The dentist wrote the following order: "Please assist [R62] with his oral hygiene after meals and at bedtime." R62's plan of care reviewed on 1/13/12, directed staff to remind R62 to do his oral care twice daily, noting he may require supervision. It lacked the new directive for increased oral hygiene. During interview at 12:30 p.m. on 2/2/12, DON stated the new directive from the dentist should have been revised on the current plan of care to ensure he received the oral care assistance after meals and at bedtime as ordered. The facility's Care Plans policy, effective 3/10, revealed that resident care plans were to be reviewed and updated monthly and as changes in care occurred. The facility did not follow this policy in regards to R63's significant weight loss and R62's oral care.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		

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F 309	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide positioning services for 1 of 3 residents (R101) reviewed in the sample for positioning. Findings include: During two meal observations, R101 was not positioned in an upright position to minimize her risk of choking. R101 had multiple diagnoses that included history of a pelvic fracture, right hip fracture without repair, pneumonia, severe mood disorder, anemia, Alzheimer's disease, dementia and vomiting. R101's significant change minimum data set (MDS) dated 11/30/11, identified she was rarely or never understood and required extensive assistance of one with eating and repositioning. The adaptive positioning log dated 11/18/11, was completed by the occupational therapist (OT), and recommended to change R101 to a Broda chair for positioning needs and skin integrity due to a recent hip fracture. The document instructed staff that R101 was "to be positioned in upright position during meds (or any time eating)." R101's plan of care last updated 1/30/12 indicated to use a Broda chair for proper positioning and comfort.	F 309		

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F 309	Continued From page 8 During continuous dining observation from 5:30 p.m. to 6:10 p.m. on 1/30/12, R101 was in a Broda, high-back wheelchair. R101 was reclined at approximately a 60 degree angle from the beginning to the end of meal service and needed assistance of one staff with eating. R101 made ten attempts throughout the meal to sit in an upright position herself. During continuous dining observation at 8:25 a.m. to 9:14 a.m. on 1/31/12, R101 was wheeled to the dining room in her Broda, high-back wheelchair and was placed in front of a table. R101 was again noted to be in the reclined position. R101 received her meal tray at 8:47 a.m. and remained reclined at approximately a 60 degree angle. At 8:51 a.m., staff started to assist R101 with eating. At 8:57 a.m., R101 took a bite of hot cereal and began coughing. At 9:01 a.m., R101 was handed a glass of water, took a sip and began coughing. R101 attempted to sit herself up at this time to take another sip of the water. At 9:01 a.m., nursing assistant (NA)-A asked R101, "Do you want to sit up more?" R101 replied, "Yes." NA-A proceeded to position R101 in a more upright position at approximately a 75 degree angle and went back to assisting other residents. R101 made many attempts to sit herself up by grabbing at the ends of her wheelchair armrests and pulling herself forward, even after her chair was adjusted to the 75 degree angle. R101 was unable to maintain an upright position during these attempts. R101 was not positioned at an upright, 90 degree angle throughout the meal service. During interview at 11:54 a.m. on 2/1/12, OT confirmed that R101 used a Broda chair. OT	F 309		

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F 309	Continued From page 9 stated R101 had a history of eating too fast and gagging on foods. OT confirmed that in general, residents with a history of coughing, choking and gagging should have been positioned in an upright position while eating. During follow-up interview at 12:15 p.m., OT reported that the staff assisting with dining the morning of 1/31/12 confirmed they did not position R101 in an upright position during her meal. During follow-up interview at 12:40 p.m., OT stated that R101 was supposed to be seated in an upright position. During interview at 1:50 p.m. on 2/1/12, nursing assistant (NA)-B stated the hospice nurse had instructed staff that R101 should be sitting upright at meal times. NA-B confirmed during the evening meal on 1/30/12 that R101 was not positioned in the upright position for the meal. NA-B stated she should have sat her up but was not familiar with R101. NA-B confirmed that for the past few days R101 had some coughing episodes with eating but was on hospice and was provided foods per choice or preference. During interview at 2:01 p.m. on 2/1/12, director of nursing (DON) stated it was a standard of practice that nursing assistants ensured all residents were positioned up an upright position to eat. DON confirmed R101's Broda chair should have been positioned in an upright position while eating or drinking.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.	F 311		

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F 311	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not provide supervision and encouragement for activities of daily living related to oral care for 1 of 4 residents (R62) reviewed for activities of daily living. Findings include: R62 was diagnosed with dementia and was identified as having poor decision making skills. The annual minimum data set (MDS) completed on 10/3/11 noted R62 had moderately impaired cognition and required supervision, oversight, cueing and set up assistance for personal hygiene tasks. During observation at 1:47 p.m. on 1/30/12, R62 was noted to have some upper teeth missing. Review of an oral assessment completed on 9/28/11, revealed R62 had broken teeth, missing teeth and signs/symptoms of decay. The oral assessment noted staff would continue to assist/supervise R62 with oral cares. A dental consult form dated 10/10/11, indicated R62 was seen by a dentist and was identified with multiple areas of decay. The plan of care revised on 1/13/12 directed staff to remind R62 to do his oral care twice daily and noted he may require supervision. During observation at 7:15 a.m. on 2/1/12 R62	F 311		

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F 311	Continued From page 11 was in his room, getting ready for breakfast. At 7:40 a.m., R62 was lying in bed reading the local paper looking nicely dressed. When asked, he stated he brushed his own teeth and usually did it before breakfast. R62 did not have a toothbrush at or in his bedside table, only a tube of toothpaste. R62's bathroom contained a green toothbrush which was wedged in an upright position between the clip of the wall mirror and the paper towel dispenser. At 8:40 a.m., R62 went to breakfast without brushing his teeth. At 9:31 a.m., R62 returned to his room via a four-wheeled walker and lied down on his bed. He remained resting in his room on his bed. At 11:00 a.m., the toothbrush remained in the same position and was dry. At 12:15 p.m., R62 went to the dining room to eat his lunch and returned to his room. He then lied down and read the paper. When interviewed at 1:30 p.m. on 2/1/12, R62 stated he had not brushed his teeth for the day yet. He stated that his toothbrush was the green toothbrush in the bathroom. At 2:00 p.m. on 2/1/12, the toothbrush was still observed to be dry. When interviewed, nursing assistant (NA)-B stated R62 was able to brush his own teeth but required supervision with his grooming in the bathroom. She was unable to verify that he had been cued or prompted to do so that day. She stated she could go to make sure he would do it now. At 11:00 a.m. on 2/2/12, R62's toothbrush was in the same location and was completely dry. NA-C stated that R62 basically took care of himself and they only really needed to check him for incontinence. She stated R62 was at church	F 311		

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F 311	Continued From page 12 services at the time of the interview, but they could have him brush his teeth when he returned. During interview at 1:30 p.m. on 2/2/12, registered nurse (RN)- C stated she would expect that a resident on the memory loss unit would be monitored and observed to have complete oral hygiene tasks to ensure they would be done. She stated that one could not rely on a person with memory loss to always remember to do a task.	F 311		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure each resident maintained acceptable parameters of nutritional status and received interventions for their nutritional problem for 1 of 3 residents (R63) reviewed in the sample for weight loss. Findings include: R63 diagnoses included dyspnea (shortness of	F 325		

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	245325	A. BUILDING _____ B. WING _____	02/02/2012

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

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F 325	Continued From page 13 breath), chronic kidney disease, prostate cancer, weakness, osteoporosis, esophageal reflux, anxiety and depression. The admission minimum data set (MDS) dated 11/29/11 revealed R63 had moderately impaired cognition and was independent with set-up for eating. The care area assessment (CAA) dated 11/29/11 identified R63 was on a low sodium diet with regular consistency, ate independently, consumed 76-100% of his meals and had no chewing or swallowing problems. R63's weight was noted as 206 pounds. Review of the plan of care dated 12/6/11, identified R63 was at risk for altered eating status due to his diagnoses. Interventions included a low sodium diet with regular consistency, eating meals in the dining room, honoring R63's preferences and receipt of a daily multivitamin. Review of weekly vital flow sheets revealed R63's weight on 12/11/11 was 204 pounds and his weight on 1/9/12 was 190 pounds. This was a significant weight loss of 7.8%, in one month. R63's most recent weight taken on 1/24/12 was noted as 186 pounds. Review of physician orders dated 1/30/12 indicated R63 was not prescribed a nutritional supplement and was not on a prescribed weight loss program. Review of the medication administration record (MAR) dated 1/1/12 to 1/31/11 revealed R63 did not receive a nutritional supplement. During observation in the main dining room from	F 325		

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F 325	Continued From page 14 11:27 a.m. to 12:05 p.m. on 2/1/12, R63 was noted to consume 25-50% of the meal he was served. During interview at 12:05 p.m. on 2/1/12, R63 reported that he was full and that he ate what he wanted. R63 verified he did not have as much of an appetite as he had in the past. During interview at 12:25 p.m. on 2/1/12, nursing assistant (NA)-A explained the facility weighing process to writer. NA-A reported that if there was a three pound weight difference, NAs were to re-weigh the resident and weights were to be recorded in the MAR. NA-A indicated she was not responsible for reporting a weight loss to other facility staff. During interview at 12:40 p.m. on 2/1/12, licensed practical nurse (LPN)-A verified that it was the floor nurse's responsibility to identify weight loss concerns based on the weights recorded in the MAR. LPN-A reported that if she noticed a weight loss, she would have the resident re-weight and look for possible causes of the weight loss. During interview at 12:47 p.m. on 2/1/12, registered nurse (RN)-A verified she would expect to be informed by the LPNs if a resident had weight loss concerns. RN-A verified she had not been informed of R63's weight loss until 1/31/12. During interview at 1:45 p.m. on 2/1/12, certified dietary manager (CDM) reported that she identified R63 had weight loss during the first week of January when she reviewed his weights	F 325		

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F 325	Continued From page 15 in preparation for an assessment. CDM stated that when she identified the weight loss, she reported it to RN-B, but RN-B had since ended her employment with the facility. CDM reported she was unaware that RN-A had not been informed of the weight loss until 1/31/12. CDM indicated that R63 was still within his "ideal body weight" range and thought his weight loss could have been related to his increase in ambulation since his admission to the facility. During follow-up interview at 9:49 a.m. on 2/2/12, CDM added that upon identifying R63's weight loss, she talked to R63 and discovered he had a "poor appetite." CDM reported that she generally discussed any resident she had identified with weight loss issues at "Tuesday meetings," where nutritional concerns were regularly discussed. However, CDM could not verify and had no evidence to indicate she had discussed R63's weight loss with other interdisciplinary team members. CDM reported that she did inform registered dietician (RD) when she visited the facility "last week" that R63 had experienced weight loss, but verified there was no evidence to verify the RD was informed or to support R63 had been seen by RD during her visit. At 1:45 p.m. on 2/2/12, CDM added that she had informed the facility's nursing department of R63's poor appetite at the time she identified his weight loss. CDM verified that intake records were not initiated for R63, but added that it was the responsibility of the nursing department to initiate recording of a resident's intake. During interview at 2:00 p.m. on 2/2/12, director of nursing (DON) described the facility policies and procedures related to weight loss. DON reported that NAs weighed each resident weekly	F 325		

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F 325	Continued From page 16	F 325		

during their baths and were expected to re-weigh a resident if there was a five pound weight loss or gain. The weights were then to be recorded in the MAR. DON verified the LPNs were then responsible for reviewing the weights recorded and reporting concerns to the RNs. DON verified there were no records of R63's intake, evidence of interdisciplinary discussion, or interventions put in place for R63's weight loss since it was initially discovered by the CDM on 1/9/12 until 1/31/12.

During interview at 2:30 p.m. on 2/2/12, RD verified that if a referral had been made for R63 to seen, there would have been notes indicating the referral and the follow-up in the medical record. RD verified that "typical practice" was for weight loss to be addressed by the RN's and then for a referral to be made to RD. Upon brief review of R63's record, RD reported that she would "typically" have expected interventions be put into place by the facility's nursing department and a referral for R63 to be seen by RD during her monthly visit to the facility. RD verified that "ideal body weight" was not the best indicator for an elderly resident's nutritional status. RD added that for most residents, the goal was to maintain a residents "usual body weight."

The facility's Bath/ Weight Protocol, updated 12/22/08, revealed a five pound weight gain or loss required an immediate re-weigh, as well as a re-weigh the following morning. If the weight change was validated by the re-weigh, the nurse was responsible for notifying the care manager/RN via an interdisciplinary note. The facility did not follow this protocol for R63.

The facility's Meal Intake Project, dated 2/24/09,

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F 325	Continued From page 17 revealed any resident determined to be at risk would have their meal intakes monitored for two weeks and then reviewed for further need by the appropriate care manager/RN. The policy added that the dietary director was to let nursing know of any residents with significant weight loss or residents with poor appetite. Meal intake was identified as beneficial in that dietary as well as nursing would be able to evaluate intake in order to respond to weight loss or gain. The policy identified residents with poor appetite and residents who had a significant weight loss of greater than five pounds in one month were at risk. The facility did not follow this policy for R63.	F 325		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441		

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F 441	Continued From page 18 (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility did not ensure implementation of hand hygiene practices consistent with accepted standards of practice to reduce the spread of infections and prevent cross-contamination for 1 of 1 residents (R63) reviewed in the sample for urinary catheter use and 1 of 3 residents (R42) reviewed in the sample for pressure ulcers. Findings include: Observation of catheter care for R63 revealed hand hygiene techniques that were not consistent with accepted standards of practice. R63 diagnoses included chronic kidney disease, prostate cancer, weakness and osteoporosis. The admission minimum data set (MDS) dated	F 441		

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F 441	Continued From page 19 11/29/11 revealed R63 had moderately impaired cognition and required extensive assistance for dressing and toilet use. The MDS also indicated R63 required an indwelling suprapubic catheter. During observation from 9:34 a.m. to 9:44 a.m. on 2/1/12, licensed practical nurse (LPN)-A was noted to complete catheter cares for R63 in his resident room. LPN-A was noted to use gloved hands and a wet wash cloth to wipe around R63's suprapubic catheter site and the catheter tubing. LPN-A was noted to remove the glove from her right hand, leaving the glove on her left hand. LPN-A was then noted to handle a clean gauze with her gloved, left hand and use her ungloved, right hand to remove a scissors from her right pocket and cut a slit in the gauze. LPN-A then used both hands to place the gauze onto R63's suprapubic catheter site. LNP-A was noted to then remove the glove from her left hand and offered R63 a sip of water out of the water mug in his room, holding the handle of the cup to help him drink. LPN-A then washed her hands. LPN-A failed to remove both of her gloves and failed to wash or sanitize her hands between cleaning R63's suprapubic catheter site/tubing and handling/applying the clean gauze. LPN-A also failed to wash her hands or sanitize before handling R63's water mug. During interview at 9:50 a.m. on 2/1/12, LPN-A reported that she did not believe the facility policy required her to wash her hands between catheter care and placing clean gauze or offering water. LPN-A stated, "It's a clean procedure." During interview at 10:30 a.m. on 2/2/12, director of nursing (DON) reported that she did not expect	F 441		

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F 441	Continued From page 20 her nurses to wash or sanitize their hands between each step in providing a treatment. DON stated, "It's not realistic." DON did verify that LPN-A should have removed both of her gloves prior to handling the clean gauze. Observation of wound care for R42 revealed hand hygiene techniques that were not consistent with accepted standards of practice. R42's diagnoses included diabetes type II, history of shingles in his right foot head, and peripheral neuropathy. The quarterly MDS dated 12/22/11 revealed R42 had no cognitive impairments, was at risk for pressure ulcer development and had a diabetic foot ulcer. The physician orders dated 1/25/12 instructed to cleanse the pressure ulcer wound on his right heel with a diluted betadine swab, rinse with normal saline, apply skin prep to the skin surrounding the wound, apply vanicream to the skin bed, apply silver gauze foam and cover with a tegaderm dressing. The orders identified on 1/19/12, R42 had Methicillin-Resistant Staphylococcus Aureus (MRSA) infection in his foot wound. During observation from 6:46 a.m. to 7:01 a.m. on 2/1/12, LPN-B was noted to complete wound care for R42 in his shared resident room. LPN-B was noted to use gloved hands and removed the soiled dressing covering the wound on R42's right heel. LPN-B then used a diluted betadine swab to cleanse the wound and rinsed it with normal saline. LPN-B was noted to remove her gloves and without sanitizing or washing her hands,	F 441		

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F 441	Continued From page 21 placed new gloves on both hands and handled/applied the clean dressing and treatment. LPN-B failed to wash or sanitize her hands between ungloving and going from a dirty to clean dressing/treatment. During interview at 11:15 a.m. on 2/1/12, LPN-B reported she did not believe the facility policy required her to wash her hands between handling a dirty dressing and apply a clean dressing/treatment. LPN-B stated, "It's not a sterile procedure." During interview at 10:30 a.m. on 2/2/12, DON reported that she did not expect her nurses to complete hand hygiene between each step in during a treatment. DON stated her expectation was that staff washed their hands before and after the entire treatment was completed. DON stated, "It's not realistic for staff to stop in the middle of a treatment and wash their hands." The facility policy for Handwashing/Hand Hygiene, undated, revealed hand washing with antimicrobial or non-antimicrobial soap and water was to be performed after contact with blood, body fluids, secretions, mucous membranes, or non-intact skin. The policy identified the use of gloves does not replace handwashing. The policy added that an alcohol-based hand rub was to be used if hands were not visibly soiled during the following situations: after handling used dressings, before handling clean dressings or gauze pads, after contact with a resident's intact skin and after removing gloves when a task is completed. This policy was not followed during the observation of R63's catheter care and R42's dressing change.	F 441		

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Foley Nursing Center
January 30th-February 2, 2012
F-166 483.10 (f)(2) Grievances

The Foley Nursing Center ensures that a resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

Review of Resident #75 family concern related to missing item of a watch. This report was consistent with information posted on employee communication board. Noted attempts to locate item with family, laundry and search of secure memory care unit on which the resident resides. Information was reviewed with Social Services by care manager who took initial report. Facility form was completed on 2/1/12 and re-education of CM-A was completed same day on facility policy and procedure for reporting missing items.

An audit of communication board notices of the last 2 months was completed with the intent to identify any further missing item notices that were not forwarded using the facility missing item report. None were noted. This was completed by 2/10/12.

All staff education on facility policy and procedures related to Missing Items is to be completed by 2/29/12.

Random weekly audits of staff communication board and 10 % of Missing item reports will be completed by Director of Nursing, or designee by March 13th, 2012. Any evidence of trending will be reported to the Continuing Quality Improvement Committee.

Random monthly audits of 10 % of Missing item reports will be completed by Director of Nursing, or designee.. Any evidence of trending will be reported to the Continuing Quality Improvement Committee. 3-13-12

This plan of correction constitutes our allegation of compliance.

Foley Nursing Center
January 30th-February 2nd 2012
Plan of Correction

F280 483.20(d)(3), 483.10(k)(2) Comprehensive Care Plans

The residents of the Foley Nursing Center have the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. This care plan will continue to be periodically reviewed and revised by a team of qualified persons after each assessment.

On 2/2/12 needs of Resident # 62 were reviewed by Nursing. The resident care plan was updated to reflect needs related to oral hygiene and staff were informed of changes.

Care plan and needs of Resident #63 to be reviewed by RN and Dietary Director, and appropriate changes to reflect resident's needs to be completed by 2/2/12.

Random care plan audits of 10% of current residents were completed by Director of Nursing by 2/20/12 in order to identify any further resident concerns related to care-planning. No further concerns identified at that time.

Nurses and Dietary Director to be re-educated on policy and procedure related care plan review and care planning to be completed by 3/02/12.

Random weekly audits of 10% of residents care plans to be completed by Director of Nursing or designee. Any evidence of trending will be reported to Continuing Quality Improvement Committee, by Director of Nursing or designee. This will be completed by March 13, 2012. 3-13-12

Random audits of 10 % of resident charts to be completed monthly by Quality Assurance Nurse or designee. Any evidence of trending will be reported to Continuing Quality Improvement Committee, by Director of Nursing or designee.

This plan of correction constitutes our allegation of compliance.

Foley Nursing Center
January 30th-February 2, 2012
F- 309 483.25 Provide Care/Services for highest well being.

The Foley Nursing Center uses the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The chart for Resident #101 was reviewed by the Director of Nursing. In collaboration with OT it was determined that Resident #101 plan of care continues to reflect needs. Therapy Director re-educated staff responsible for positioning resident on 2/1/12 on proper positioning of wheelchair to allow for resident participation of meal time as able. This re-education was completed on 2/1/12.

Review of residents with specialized wheelchair positioning was completed on 2/1/12 by therapy staff as a audit in order to identify any trending. None noted. Care plans continued to reflect residents needs.

Random weekly audits of positioning of wheelchairs on 10 % of those residents are to be completed by therapy staff or designee. Any evidence of trending will be reported to the Continuing Quality Improvement Committee. This is to be completed by March 13, 2012.

3-13-12

Random monthly audits of 10% of current resident with specialized wheelchair positioning. Any evidence of trending will be reported to Continuing Quality Improvement Committee, by Director of Nursing or designee.

This plan of correction constitutes our allegation of compliance.

Foley Nursing Center
January 30th-February 2, 2012
F- 311 483.25 TREATMENTS/SERVICES TO IMPROVE/MAINTAIN ADLS

The Foley Nursing Center ensures a resident is given the appropriate treatment and services to maintain or improve his or her abilities.

The chart for Resident #62 was reviewed by the Director of Nursing on 02/02/12 it was noted that recommendations were written on a Dental Consult form recommending encouragement of oral hygiene after meals and hs. This information was not placed on resident care plan. Changes were made on 02/02/12 to reflect that recommendation.

Charts of all residents with consults from 12/11 to 2/12 were reviewed by the Director of Nursing to audit for transference of information from consult form to care plan. No trending noted.

Re-education of nurses and health unit coordinators related to facility procedures on transcription of orders and for nurses, care planning will be completed by 3/02/12.

Random weekly audits of consult information on 10 % of those residents are to be completed by Director of Nursing or designee. Any evidence of trending will be reported to the Continuing Quality Improvement Committee. This is to be completed by March 13th, 2012.

3-13-12

Random monthly audits of 10% of current resident with consults will be completed. Any evidence of trending will be reported to Continuing Quality Improvement Committee, by Director of Nursing or designee.

This plan of correction constitutes our allegation of compliance.

Foley Nursing Center
January 30th-February 2, 2012
F 325 483.25 (i) Maintain nutrition status unless unavoidable

The Foley Nursing Center maintains acceptable parameter of nutritional status, such as body weight and protein levels unless the resident's condition demonstrates that this is not possible.

On 2/02/12 review of all current residents weights from Sept 2nd, 2011 to Feb. 2nd, 2012 in order to note any evidence of trending related to weight loss. No concerns were noted.

Re-education of nursing staff on facility protocol for reviewing weekly weights for evidence of loss or gain was completed by March 2nd. This includes alerts of weight changes of 5 or more pounds in one week, resident is to be re-weighed and RN care manager to be notified this information is then reviewed with Interdisciplinary team.

Facility policy on review/tracking of weights was reviewed and revised to include report generation of weight change alert report to include parameters of weight gain or loss of 5 pounds or more in 7 days and/or 2.0 % change in 7 days. A two week period will be generated and reviewed weekly at the weekly Interdisciplinary Team meeting.

Weekly audits of resident weight changes will continue using generated reports by Dietary Director in collaboration with interdisciplinary team. Any evidence of trending will be reported to the Continuing Quality Improvement Committee. These will continue to be weekly, therefore no ending date to be specified.

This plan of correction constitutes our allegation of compliance. 3-13-12

Foley Nursing Center
January 30th-February 2, 2012
F 441 483.65 Infection Control, Prevent Spread, Linens

The Foley Nursing Center has an established, and maintains an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

Facility policies for hand washing and catheter care were reviewed and updated in accordance with CDC guidelines.

Re-education of LPN-A and LPN-B on facility policy and procedure will be completed by 2/29/12.

All staff education on updated hand washing policy will be completed by 2/29/12 and nursing staff education on catheter care policy will also be completed by 3/02/12..

Random weekly audits of 10 % of resident dressing changes and/or catheter cares will be completed by Director of Nursing or designee, in order to identify any concerns. Any evidence of trending will be reported to the Continuing Quality Improvement Committee. This will be completed by March 13th, 2011.

Monthly care audits will be completed on 10 % of residents with catheter care and/or dressing changes by Director of Nursing or designee and any evidence of trending will be reported to the Continuing Quality Improvement Committee. 3-13-12

This plan of correction constitutes our allegation of compliance.

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FOLEY NURSING CENTER	253 PINE STREET FOLEY, MN 56329

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K 000	INITIAL COMMENTS	K 000	POC ok TS 3-2-12 see attached	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by: Based on observations, the facility has failed to provide proper protection from 1 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (2000 edition) section 19.3.2.1. The following deficient practice could negatively affect 10 of 79 residents, staff and visitors as smoke and fire in this rooms could enter the corridor making it untenable, Findings include: On facility tour between 1:00 PM to 4:00 PM on 02/01/2012, observation revealed, that there are several penetrations located in the 200 wing Medication / Nurses Storage Room that were not	K 029	RECEIVED FEB 29 2012 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION See attached POC All completion dates are 2/2/2012	

DC: 03.14.2012

EXIT: 02.02.2012

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

Administrator 2/27/12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245325	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/01/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 1 sealed with construction material and an approved intumescent fire calking. This deficient practice was verified by the Environmental Services Director (BR).	K 029		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 LSC (00) section 19.7.6, 4.6.12. This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect all patients, staff and visitors. Findings include: On facility tour between 1:00 PM to 4:00 PM on 02/01/2012, during a review of the available fire sprinkler test and inspection documentation, observations revealed and were confirmed by interview with the Environmental Services Director (CZ), that the facility failed to provide documentation for 1 of 4 fire sprinkler flow tests	K 062		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 062	Continued From page 2 of the facility's fire sprinkler system. This deficient practice was verified by the Environmental Services Director (BR).	K 062		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by: Based on documentation review and observations, it was determined that the facility has failed to ensure that cleaning and inspection of the kitchen hood system protecting the cooking appliances has been completed. NFPA 96 8-3.1 per table 8-3.1, states that for moderate-volume cooking operations, the hood system and components shall be inspected and maintained semiannually by a properly trained, qualified, and certified company or person. This deficient practice could affect 20 of 79, staff and visitors. Findings Include: On facility tour between 1:00 PM to 4:00 PM on 02/01/2012, during the review of all available documentation for the kitchen hood ventilation ans suppression system inspection reports and observations made of the kitchen hood ventilation ans suppression system inspection tags it was revealed that the facility had failed to ensure that the system has been inspected every 6 months. This deficient practice was verified by the Environmental Services Director (BR).	K 069		

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Foley Nursing Center
February 1, 2012
Plan of Correction

K 029

To ensure the safety of our residents, visitors and staff the maintenance department of the Heritage of Foley Campus have repaired the open penetrations in the 200 wing medication/nurses storage room with fire retardant wall board and sealed with an approved intumescent fire caulk.

This was completed on February 2, 2012

This plan of correction constitutes our allegation of compliance.

Foley Nursing Center
February 1, 2012
Plan of Correction

K 062

To ensure the safety of our residents, visitors, and staff, the maintenance department of the Heritage of Foley campus has designed dual charting to record the documentation of the quarterly sprinkler flow tests.

This was completed on February 2, 2012.

This plan of correction constitutes our allegation of compliance.

Foley Nursing Center
February 1, 2012
Plan of Correction

K 069

To ensure the safety of our residents, visitors and staff, the Environmental Service Director has contracted with a properly trained, qualified and certified company semi annual inspections of the facilities kitchen hood system.

This was completed on February 2, 2012 by the Environmental Services Director.

This plan of correction constitutes our allegation of compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245325	A. BUILDING 02 - 2008 ADDITIONS B. WING _____	02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS	K 000		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 LSC (00) section 18.7.6, 4.6.12. This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect all patients, staff and visitors. Findings include: On facility tour between 1:00 PM to 4:00 PM on 02/01/2012, during a review of the available fire sprinkler test and inspection documentation, observations revealed and were confirmed by interview with the Environmental Services Director (CZ), that the facility failed to provide documentation for 1 of 4 fire sprinkler flow tests of the facility's fire sprinkler system. This deficient practice was verified by the Environmental Services Director (BR).	K 062	POC ok JS 2-2-12 See attached POC all completion dates are 2/2/2012 RECEIVED FEB 29 2012 MN DEPT OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 2/27/12

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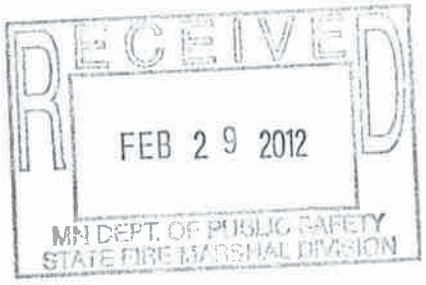
Foley Nursing Center
February 1, 2012
Plan of Correction

K 062

To ensure the safety of our residents, visitors, and staff, the maintenance department of the Heritage of Foley campus has designed dual charting to record the documentation of the quarterly sprinkler flow tests.

This was completed on February 2, 2012.

This plan of correction constitutes our allegation of compliance.



MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3051 4877

February 14, 2012

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5325021

Dear Mr. Oelrich:

The above facility was surveyed on January 30, 2012 through February 2, 2012 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction

and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 3333 West Division Street, Suite 212, St. Cloud, Minnesota 56301-4557. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Marge Meeker

Marge Meeker, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (320) 223-7317 Fax: (320) 223-7348

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00629	A. BUILDING _____ B. WING _____	02/02/2012

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On, January 30, 31, Feburary 1 and 2, 2012, surveyors of this Department's staff, visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 Monitoring, Licensing and Certification Program; 3333 West Division St, Suite 212, St. Cloud, MN 56301-4557	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B.	2 570		

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2 570	Continued From page 2 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure each resident's plan of care was updated as necessary to meet the needs of the resident, related to significant weight loss for 1 of 3 residents (R63) reviewed in the sample for weight loss, and related to oral care for 1 of 4 residents (R62) in the sample reviewed for activities of daily living. Findings include: The facility did not revise R63's plan of care to include interventions to address significant weight loss. R63 diagnoses included dyspnea (shortness of breath), chronic kidney disease, prostate cancer, weakness, osteoporosis, esophageal reflux, anxiety and depression. The admission minimum data set (MDS) dated 11/29/11 revealed R63 had moderately impaired cognition and was independent with set-up for eating. The care area assessment (CAA) dated 11/29/11 identified R63 was on a low sodium diet with regular consistency, ate independently, consumed 76-100% of his meals and had no chewing or swallowing problems. R63's weight was noted as 206 pounds. Review of the plan of care dated 12/6/11, identified R63 was at risk for altered eating status due to his diagnoses. Interventions included a low sodium diet with regular consistency, eating meals in the dining room, honoring R63's preferences and receipt of a daily multivitamin.	2 570		

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2 570	Continued From page 3 Review of weekly vital flow sheets revealed R63's weight on 12/11/11 was 204 pounds and his weight on 1/9/12 was 190 pounds. This was a significant weight loss of 7.8% in one month. R63's most recent weight taken on 1/24/12 was noted as 186 pounds. Review of physician orders dated 1/30/12 indicated R63 was not prescribed a nutritional supplement and was not on a prescribed weight loss program. Review of the medication administration record (MAR) dated 1/1/12 to 1/31/12 revealed R63 did not receive a nutritional supplement. During interview at 12:47 p.m. on 2/1/12, registered nurse (RN)-A verified she had not been informed of R63's weight loss until 1/31/12. During interview at 1:45 p.m. on 2/1/12, certified dietary manager (CDM) reported that she identified R63 had weight loss during the first week of January when she reviewed his weights in preparation for an assessment. CDM stated that when she identified the weight loss, she reported it to RN-B, but RN-B had since ended her employment with the facility. CDM reported she was unaware that RN-A had not been informed of the weight loss until 1/31/12. During follow-up interview at 9:49 a.m. on 2/2/12, CDM added that upon identifying R63's weight loss, she talked to R63 and discovered he had a "poor appetite." CDM reported that she informed registered dietician (RD) when she visited the facility "last week" that R63 had experienced weight loss. At 1:45 p.m. on 2/2/12, CDM added that she had informed the facility's nursing department of R63's poor appetite at the time she	2 570		

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2 570	Continued From page 4 identified his weight loss. CDM verified that intake records were not initiated for R63, but added that it was the responsibility of the nursing department to initiate recording of a resident's intake. During interview at 2:00 p.m. on 2/2/12, director of nursing (DON) described the facility policies and procedures related to weight loss. DON reported that NAs weighed each resident weekly during their baths and were expected to re-weigh a resident if there was a five pound weight loss or gain. The weights were then to be recorded in the MAR. DON verified the LPNs were then responsible for reviewing the weights recorded and reporting concerns to the RNs. DON verified there were no records of R63's intake, evidence of interdisciplinary discussion or evidence of interventions added to the plan of care for R63's weight loss since it was initially discovered by the CDM on 1/9/12, until 1/31/12. During interview at 2:30 p.m. on 2/2/12, RD verified that if a referral had been made for R63 to be seen, there would have been notes indicating the referral and the follow-up in the medical record. RD verified that "typical practice" was for weight loss to be addressed by the RN's and then for a referral to be made to RD. Upon brief review of R63's record, RD reported that she would "typically" have expected interventions be put into place by the facility's nursing department and a referral for R63 to be seen by RD during her monthly visit to the facility. R62's care plan was not revised to reflect a dental consult recommendation to increase oral hygiene. According to a facility Consult Form dated 11/2/11, the resident was seen by the dentist for	2 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 570	Continued From page 5 restoration of some decayed teeth. The dentist wrote the following order: "Please assist [R62] with his oral hygiene after meals and at bedtime." R62's plan of care reviewed on 1/13/12, directed staff to remind R62 to do his oral care twice daily, noting he may require supervision. It lacked the new directive for increased oral hygiene. During interview at 12:30 p.m. on 2/2/12, DON stated the new directive from the dentist should have been revised on the current plan of care to ensure he received the oral care assistance after meals and at bedtime as ordered. The facility's Care Plans policy, effective 3/10, revealed that resident care plans were to be reviewed and updated monthly and as changes in care occurred. The facility did not follow this policy in regards to R63's significant weight loss and R62's oral care. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop a system to educate staff and develop a monitoring system to ensure staff are reviewing and revising the care plan as indicated and then providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Tewnty One (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and	2 830		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 6 plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide positioning services for 1 of 3 residents (R101) reviewed in the sample for positioning. Findings include: During two meal observations, R101 was not positioned in an upright position to minimize her risk of choking. R101 had multiple diagnoses that included history of a pelvic fracture, right hip fracture without repair, pneumonia, severe mood disorder, anemia, Alzheimer's disease, dementia and vomiting. R101's significant change minimum data set (MDS) dated 11/30/11, identified she was rarely or never understood and required extensive assistance of one with eating and repositioning. The adaptive positioning log dated 11/18/11, was completed by the occupational therapist (OT), and recommended to change R101 to a Broda chair for positioning needs and skin integrity due to a recent hip fracture. The document instructed staff that R101 was "to be positioned in upright	2 830		

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	00629	A. BUILDING _____ B. WING _____	02/02/2012

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2 830	Continued From page 7 position during meds (or any time eating)." R101's plan of care last updated 1/30/12 indicated to use a Broda chair for proper positioning and comfort. During continuous dining observation from 5:30 p.m. to 6:10 p.m. on 1/30/12, R101 was in a Broda, high-back wheelchair. R101 was reclined at approximately a 60 degree angle from the beginning to the end of meal service and needed assistance of one staff with eating. R101 made ten attempts throughout the meal to sit in an upright position herself. During continuous dining observation at 8:25 a.m. to 9:14 a.m. on 1/31/12, R101 was wheeled to the dining room in her Broda, high-back wheelchair and was placed in front of a table. R101 was again noted to be in the reclined position. R101 received her meal tray at 8:47 a.m. and remained reclined at approximately a 60 degree angle. At 8:51 a.m., staff started to assist R101 with eating. At 8:57 a.m., R101 took a bite of hot cereal and began coughing. At 9:01 a.m., R101 was handed a glass of water, took a sip and began coughing. R101 attempted to sit herself up at this time to take another sip of the water. At 9:01 a.m., nursing assistant (NA)-A asked R101, "Do you want to sit up more?" R101 replied, "Yes." NA-A proceeded to position R101 in a more upright position at approximately a 75 degree angle and went back to assisting other residents. R101 made many attempts to sit herself up by grabbing at the ends of her wheelchair armrests and pulling herself forward, even after her chair was adjusted to the 75 degree angle. R101 was unable to maintain an upright position during these attempts. R101 was not positioned at an upright, 90 degree angle throughout the meal	2 830		

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2 830	Continued From page 8 service. During interview at 11:54 a.m. on 2/1/12, OT confirmed that R101 used a Broda chair. OT stated R101 had a history of eating too fast and gagging on foods. OT confirmed that in general, residents with a history of coughing, choking and gagging should have been positioned in an upright position while eating. During follow-up interview at 12:15 p.m., OT reported that the staff assisting with dining the morning of 1/31/12 confirmed they did not position R101 in an upright position during her meal. During follow-up interview at 12:40 p.m., OT stated that R101 was supposed to be seated in an upright position. During interview at 1:50 p.m. on 2/1/12, nursing assistant (NA)-B stated the hospice nurse had instructed staff that R101 should be sitting upright at meal times. NA-B confirmed during the evening meal on 1/30/12 that R101 was not positioned in the upright position for the meal. NA-B stated she should have sat her up but was not familiar with R101. NA-B confirmed that for the past few days R101 had some coughing episodes with eating but was on hospice and was provided foods per choice or preference. During interview at 2:01 p.m. on 2/1/12, director of nursing (DON) stated it was a standard of practice that nursing assistants ensured all residents were positioned up an upright position to eat. DON confirmed R101's Broda chair should have been positioned in an upright position while eating or drinking. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could review and reeducate all staff on the policies and procedures to ensure that all residents are	2 830		

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2 830	Continued From page 9 properly positioned. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility did not provide supervision and encouragement for activities of daily living related to oral care for 1 of 4 residents (R62) reviewed for activities of daily living. Findings include:	2 915		

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2 915	Continued From page 10 R62 was diagnosed with dementia and was identified as having poor decision making skills. The annual minimum data set (MDS) completed on 10/3/11 noted R62 had moderately impaired cognition and required supervision, oversight, cueing and set up assistance for personal hygiene tasks. During observation at 1:47 p.m. on 1/30/12, R62 was noted to have some upper teeth missing. Review of an oral assessment completed on 9/28/11, revealed R62 had broken teeth, missing teeth and signs/symptoms of decay. The oral assessment noted staff would continue to assist/supervise R62 with oral cares. A dental consult form dated 10/10/11, indicated R62 was seen by a dentist and was identified with multiple areas of decay. The plan of care revised on 1/13/12 directed staff to remind R62 to do his oral care twice daily and noted he may require supervision. During observation at 7:15 a.m. on 2/1/12 R62 was in his room, getting ready for breakfast. At 7:40 a.m., R62 was lying in bed reading the local paper looking nicely dressed. When asked, he stated he brushed his own teeth and usually did it before breakfast. R62 did not have a toothbrush at or in his bedside table, only a tube of toothpaste. R62's bathroom contained a green toothbrush which was wedged in an upright position between the clip of the wall mirror and the paper towel dispenser. At 8:40 a.m., R62 went to breakfast without brushing his teeth. At 9:31 a.m., R62 returned to his room via a	2 915		

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2 915	Continued From page 11 four-wheeled walker and lied down on his bed. He remained resting in his room on his bed. At 11:00 a.m., the toothbrush remained in the same position and was dry. At 12:15 p.m., R62 went to the dining room to eat his lunch and returned to his room. He then lied down and read the paper. When interviewed at 1:30 p.m. on 2/1/12, R62 stated he had not brushed his teeth for the day yet. He stated that his toothbrush was the green toothbrush in the bathroom. At 2:00 p.m. on 2/1/12, the toothbrush was still observed to be dry. When interviewed, nursing assistant (NA)-B stated R62 was able to brush his own teeth but required supervision with his grooming in the bathroom. She was unable to verify that he had been cued or prompted to do so that day. She stated she could go to make sure he would do it now. At 11:00 a.m. on 2/2/12, R62's toothbrush was in the same location and was completely dry. NA-C stated that R62 basically took care of himself and they only really needed to check him for incontinence. She stated R62 was at church services at the time of the interview, but they could have him brush his teeth when he returned. During interview at 1:30 p.m. on 2/2/12, registered nurse (RN)- C stated she would expect that a resident on the memory loss unit would be monitored and observed to have complete oral hygiene tasks to ensure they would be done. She stated that one could not rely on a person with memory loss to always remember to do a task. SUGGESTED METHOD FOR CORRECTION: The DON or designee(s) could review and revise as necessary the policies and procedures	2 915		

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2 915	Continued From page 12 regarding the need for assistance with oral hygiene according to the plan of care. The DON or designee (s) could provide training for all appropriate staff on these policies and procedures. The DON or designee (s) could monitor to assure all residents are receiving adequate and appropriate care. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	2 915		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure each resident maintained acceptable parameters of nutritional status and received interventions for their nutritional problem for 1 of 3 residents (R63) reviewed in the sample for weight loss. Findings include: R63 diagnoses included dyspnea (shortness of breath), chronic kidney disease, prostate cancer, weakness, osteoporosis, esophageal reflux, anxiety and depression.	2 965		

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2 965	Continued From page 13 The admission minimum data set (MDS) dated 11/29/11 revealed R63 had moderately impaired cognition and was independent with set-up for eating. The care area assessment (CAA) dated 11/29/11 identified R63 was on a low sodium diet with regular consistency, ate independently, consumed 76-100% of his meals and had no chewing or swallowing problems. R63's weight was noted as 206 pounds. Review of the plan of care dated 12/6/11, identified R63 was at risk for altered eating status due to his diagnoses. Interventions included a low sodium diet with regular consistency, eating meals in the dining room, honoring R63's preferences and receipt of a daily multivitamin. Review of weekly vital flow sheets revealed R63's weight on 12/11/11 was 204 pounds and his weight on 1/9/12 was 190 pounds. This was a significant weight loss of 7.8%, in one month. R63's most recent weight taken on 1/24/12 was noted as 186 pounds. Review of physician orders dated 1/30/12 indicated R63 was not prescribed a nutritional supplement and was not on a prescribed weight loss program. Review of the medication administration record (MAR) dated 1/1/12 to 1/31/11 revealed R63 did not receive a nutritional supplement. During observation in the main dining room from 11:27 a.m. to 12:05 p.m. on 2/1/12, R63 was noted to consume 25-50% of the meal he was served. During interview at 12:05 p.m. on 2/1/12, R63 reported that he was full and that he ate what he	2 965		

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2 965	Continued From page 14 wanted. R63 verified he did not have as much of an appetite as he had in the past. During interview at 12:25 p.m. on 2/1/12, nursing assistant (NA)-A explained the facility weighing process to writer. NA-A reported that if there was a three pound weight difference, NAs were to re-weigh the resident and weights were to be recorded in the MAR. NA-A indicated she was not responsible for reporting a weight loss to other facility staff. During interview at 12:40 p.m. on 2/1/12, licensed practical nurse (LPN)-A verified that it was the floor nurse's responsibility to identify weight loss concerns based on the weights recorded in the MAR. LPN-A reported that if she noticed a weight loss, she would have the resident re-weight and look for possible causes of the weight loss. During interview at 12:47 p.m. on 2/1/12, registered nurse (RN)-A verified she would expect to be informed by the LPNs if a resident had weight loss concerns. RN-A verified she had not been informed of R63's weight loss until 1/31/12. During interview at 1:45 p.m. on 2/1/12, certified dietary manager (CDM) reported that she identified R63 had weight loss during the first week of January when she reviewed his weights in preparation for an assessment. CDM stated that when she identified the weight loss, she reported it to RN-B, but RN-B had since ended her employment with the facility. CDM reported she was unaware that RN-A had not been informed of the weight loss until 1/31/12. CDM indicated that R63 was still within his "ideal body weight" range and thought his weight loss could	2 965		

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2 965	Continued From page 15 have been related to his increase in ambulation since his admission to the facility. During follow-up interview at 9:49 a.m. on 2/2/12, CDM added that upon identifying R63's weight loss, she talked to R63 and discovered he had a "poor appetite." CDM reported that she generally discussed any resident she had identified with weight loss issues at "Tuesday meetings," where nutritional concerns were regularly discussed. However, CDM could not verify and had no evidence to indicate she had discussed R63's weight loss with other interdisciplinary team members. CDM reported that she did inform registered dietician (RD) when she visited the facility "last week" that R63 had experienced weight loss, but verified there was no evidence to verify the RD was informed or to support R63 had been seen by RD during her visit. At 1:45 p.m. on 2/2/12, CDM added that she had informed the facility's nursing department of R63's poor appetite at the time she identified his weight loss. CDM verified that intake records were not initiated for R63, but added that it was the responsibility of the nursing department to initiate recording of a resident's intake. During interview at 2:00 p.m. on 2/2/12, director of nursing (DON) described the facility policies and procedures related to weight loss. DON reported that NAs weighed each resident weekly during their baths and were expected to re-weigh a resident if there was a five pound weight loss or gain. The weights were then to be recorded in the MAR. DON verified the LPNs were then responsible for reviewing the weights recorded and reporting concerns to the RNs. DON verified there were no records of R63's intake, evidence of interdisciplinary discussion, or interventions put in place for R63's weight loss since it was initially discovered by the CDM on 1/9/12 until 1/31/12.	2 965		

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2 965	Continued From page 16 During interview at 2:30 p.m. on 2/2/12, RD verified that if a referral had been made for R63 to seen, there would have been notes indicating the referral and the follow-up in the medical record. RD verified that "typical practice" was for weight loss to be addressed by the RN's and then for a referral to be made to RD. Upon brief review of R63's record, RD reported that she would "typically" have expected interventions be put into place by the facility's nursing department and a referral for R63 to be seen by RD during her monthly visit to the facility. RD verified that "ideal body weight" was not the best indicator for an elderly resident's nutritional status. RD added that for most residents, the goal was to maintain a residents "usual body weight." The facility's Bath/ Weight Protocol, updated 12/22/08, revealed a five pound weight gain or loss required an immediate re-weigh, as well as a re-weigh the following morning. If the weight change was validated by the re-weigh, the nurse was responsible for notifying the care manager/RN via an interdisciplinary note. The facility did not follow this protocol for R63. The facility's Meal Intake Project, dated 2/24/09, revealed any resident determined to be at risk would have their meal intakes monitored for two weeks and then reviewed for further need by the appropriate care manager/RN. The policy added that the dietary director was to let nursing know of any residents with significant weight loss or residents with poor appetite. Meal intake was identified as beneficial in that dietary as well as nursing would be able to evaluate intake in order to respond to weight loss or gain. The policy identified residents with poor appetite and residents who had a significant weight loss of	2 965		

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2 965	Continued From page 17 greater than five pounds in one month were at risk. The facility did not follow this policy for R63. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing (DON) or designee could develop and implement policies and procedures to ensure residents at nutritonal risk received appropriate interventions to maintain nutritional status. The DON or her designee could educate all appropriate staff on the policies and procedures. The DON could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 965		
21395	MN Rule 4658.0805 Persons Providing Services All persons providing services, including volunteers, with a communicable disease as listed in part 4605.7040 or with infected skin lesions must not be permitted to work in the nursing home unless it is determined that the person's condition will permit the person to work without endangering the health and safety of residents and other staff. The employee health policies required in part 4658.0800, subpart 4, item F, must address grounds for excluding persons from work and for reinstating persons to work due to a communicable disease or infected skin lesions. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility did not ensure implementation of hand hygiene practices consistent with accepted standards of practice to reduce the spread of infections and prevent	21395		

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21395	Continued From page 18 cross-contamination for 1 of 1 residents (R63) reviewed in the sample for urinary catheter use and 1 of 3 residents (R42) reviewed in the sample for pressure ulcers. Findings include: Observation of catheter care for R63 revealed hand hygiene techniques that were not consistent with accepted standards of practice. R63 diagnoses included chronic kidney disease, prostate cancer, weakness and osteoporosis. The admission minimum data set (MDS) dated 11/29/11 revealed R63 had moderately impaired cognition and required extensive assistance for dressing and toilet use. The MDS also indicated R63 required an indwelling suprapubic catheter. During observation from 9:34 a.m. to 9:44 a.m. on 2/1/12, licensed practical nurse (LPN)-A was noted to complete catheter cares for R63 in his resident room. LPN-A was noted to use gloved hands and a wet wash cloth to wipe around R63's suprapubic catheter site and the catheter tubing. LPN-A was noted to remove the glove from her right hand, leaving the glove on her left hand. LPN-A was then noted to handle a clean gauze with her gloved, left hand and use her ungloved, right hand to remove a scissors from her right pocket and cut a slit in the gauze. LPN-A then used both hands to place the gauze onto R63's suprapubic catheter site. LNP-A was noted to then remove the glove from her left hand and offered R63 a sip of water out of the water mug in his room, holding the handle of the cup to help him drink. LPN-A then washed her hands. LPN-A failed to remove both of her gloves and failed to wash or sanitize her hands between	21395		

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21395	Continued From page 19 cleaning R63's suprapubic catheter site/tubing and handling/applying the clean gauze. LPN-A also failed to wash her hands or sanitize before handling R63's water mug. During interview at 9:50 a.m. on 2/1/12, LPN-A reported that she did not believe the facility policy required her to wash her hands between catheter care and placing clean gauze or offering water. LPN-A stated, "It's a clean procedure." During interview at 10:30 a.m. on 2/2/12, director of nursing (DON) reported that she did not expect her nurses to wash or sanitize their hands between each step in providing a treatment. DON stated, "It's not realistic." DON did verify that LPN-A should have removed both of her gloves prior to handling the clean gauze. SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee(s) may review or revise policies and procedures related to infection control techniques in regards to handwashing. The director of nursing or designee (s) could provide an in-service in regard to these policies and procedures. The director of nursing or designee(s) could conduct audits to ensure the policies and procedures are being implemented. TIME PERIOD FOR CORRECTION: Ten (10) days.	21395		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as	21880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00629	A. BUILDING _____ B. WING _____	02/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21880	Continued From page 20 patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced	21880		

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21880	Continued From page 21 by: Based on interview and document review the facility failed to promptly investigate and resolve grievances related to reported missing personal property for 1 of 1 resident (R75) reviewed for missing personal property. Findings include: R75 had multiple diagnoses that included Alzheimer's disease and dementia without behaviors. During interview at 8:30 a.m. on 1/31/12 R75's family (Family-A) reported he was missing a watch. Family-A stated she reported this information to the nursing staff approximately two days prior and no one had followed-up with her. During interview at 3:54 p.m. on 1/31/12 registered nurse (RN)-D stated she was not aware R75 had any missing personal items. During interview at 3:55 p.m. on 1/31/12 clinical manager (CM)-A stated the facility's process for reported missing personal items was to fill out a concerns report, then give the report to the social worker, who then alerted the department heads. CM-A stated the social worker was then to follow up with the resident/family involved. CM-A stated she was not sure if R75 had any missing property. When cued if Family-A reported a missing watch, CM-A stated, "Oh yeah that's right." CM-A revealed that Family-A had reported the missing watch about two weeks prior and nursing filled out a concern form. A copy of the form was requested at this time. However, the facility was unable to provide evidence that a concern form was filled out for R75's missing watch.	21880		

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21880	Continued From page 22 During interview at 1:56 p.m. on 2/1/12, licensed social worker (LSW) stated the facility's process was to fill out a missing items report for reported missing personal items, pass the information on to LSW and the director of nursing (DON). LSW stated he was responsible for following-up with the resident and family. LSW confirmed he was not aware of R75's missing watch until yesterday when CM-A brought it to his attention. LSW stated he would expect this was passed on to him when Family-A reported it two weeks prior. During follow-up interview at 10:00 a.m. on 2/2/12, CM-A confirmed the facility did not follow their procedure for investigating missing personal items. The facility's Concern and Missing Item Policy instructed staff to conduct a search among the parties involved and complete a concern and resolution report or missing item report. The policy added that the concern and resolution report should be handed to the social service department. The policy indicated if the initial search was ineffective the missing item report should be given to the social worker and a copy should be placed on the communication board to notify staff of missing item. This process was not followed for R75. SUGGESTED METHOD FOR CORRECTION: The Administer or designee could review and revise the policies and procedures regarding addressing the concerns brought forth regarding missing items and to ensure that the issues brought forth are addressed, investigated and taken care of in a timely manner. TIME PERIOD FOR CORRECTION: Thirty (30)	21880		

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21880	Continued From page 23 days.	21880		