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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MHTT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00576

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245548**
2.STATE VENDOR OR MEDICAID NO.
(L2) **230743000**

3. NAME AND ADDRESS OF FACILITY
(L3)
(L4) **TUFF MEMORIAL HOME 505 EAST 4TH STREET**
(L5) **HILLS, MN** (L6) **56138**

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 **11/03/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kimberly Swenson, Deputy State Fire Marshall 11/13/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 11/14/2014 (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
03/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/17/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245548

November 14, 2014

Mr. Dana Dahlquist, Administrator
Tuff Memorial Home
505 East 4th Street
Hills, Minnesota 56138

Dear Mr. Dahlquist:

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 November 2, 2014 the above facility is certified for or recommended for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 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,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

November 13, 2014

Mr. Dana Dahlquist, Administrator
Tuff Memorial Home
505 East 4th Street
Hills, Minnesota 56138

RE: Project Number S5548023

Dear Mr. Dahlquist:

On August 28, 2014, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective September 30, 2014. (42 CFR 488.422)

This was based on the deficiencies cited by this Department for a standard survey completed on August 21, 2014, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on October 3, 2014. The most serious deficiencies at the time of the revisit were found 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 November 3, 2014, the Minnesota Departments of Health and Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on November 3, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 3, 2014. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on October 3, 2014, as of November 3, 2014. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective November 3, 2014.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of October 21, 2014. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 21, 2014, be rescinded effective November 3, 2014.. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective November 21, 2014, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective November 21, 2014, is to be rescinded.

In our letter of October 21, 2014, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 21, 2014, due to denial of payment for new admissions. Since your facility attained substantial compliance on November 3, 2014, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245548	A. Building / B. Wing: 01 - MAIN BUILDING 01	11/3/2014

Name of Facility	Street Address, City, State, Zip Code
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

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 K0038	11/03/2014	ID Prefix Reg. # NFPA 101 LSC K0052	11/03/2014	ID Prefix Reg. # NFPA 101 LSC K0144	11/03/2014
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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/KFD	11/13/2014	34764	11/03/2014
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
8/20/2014	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MHTT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00576

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245548**
2.STATE VENDOR OR MEDICAID NO.
(L2) **230743000**

3. NAME AND ADDRESS OF FACILITY
(L3) **TUFF MEMORIAL HOME**
(L4) **505 EAST 4TH STREET**
(L5) **HILLS, MN** (L6) **56138**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/03/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 10/21/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/22/2014 (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
03/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/17/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3055 0073

October 21, 2014

Mr. Dana Dahlquist, Administrator
Tuff Memorial Home
505 East 4th Street
Hills, Minnesota 56138

RE: Project Number S5548023

Dear Mr. Dahlquist:

On August 28, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 21, 2014. 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 October 3, 2014, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 21, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 2, 2014. Based on our visit, we have determined that your facility has achieved substantial compliance with the health deficiencies issued pursuant to our standard survey, completed on August 21, 2014.

However, compliance with the Life Safety Code (LSC) deficiencies issued pursuant to the August 21, 2014 standard survey conducted by the Minnesota Department Public Safety has not yet been verified. The most serious LSC deficiencies in your facility at the time of the standard survey were found 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.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective November 21, 2014. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective November 21, 2014. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 21, 2014. You should notify all Medicare/Medicaid

residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Tuff Memorial Home is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective November 21, 2014. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

A copy of the Post Certification Revisit Form (CMS-2567B) from the October 3, 2014 revisit is enclosed.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

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 February 21, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245548	A. Building B. Wing	10/3/2014

Name of Facility	Street Address, City, State, Zip Code
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

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 **F0241** Reg. # **483.15(a)** LSC	Correction Completed **09/20/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **09/20/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** KS/KFD	**Date:** 10/21/2014	**Signature of Surveyor:** 03048	**Date:** 10/03/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 8/21/2014		**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: MHTT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00576

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245548**

2.STATE VENDOR OR MEDICAID NO.
(L2) **230743000**

3. NAME AND ADDRESS OF FACILITY
(L3) **TUFF MEMORIAL HOME**
(L4) **505 EAST 4TH STREET**
(L5) **HILLS, MN** (L6) **56138**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/21/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Jodi Johnson, HFE NE II 09/12/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/15/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3051 2835

August 28, 2014

Mr. Dana Dahlquist, Administrator
Tuff Memorial Home
505 East 4th Street
Hills, Minnesota 56138

RE: Project Number S5548023

Dear Mr. Dahlquist:

On August 21, 2014, 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:

Maria King, Assistant Program Manager
Minnesota Department of Health
12 Civic Center, Plaza Suite #2105
Mankato, Minnesota 56001
Telephone: (507) 344-2716
Fax: (507) 344-2723

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 September 30, 2014, 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 September 30, 2014 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 November 21, 2014 (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 February 21, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	08/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(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 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview the facility failed to ensure that residents were treated in a dignified manner for 2 of 3 residents (R3 and R34) plus additional residents (R1, R12 and R41) who had personal care information posted on the bathroom door visible to the public. Findings include: During resident observation of R3 on 8/18/14, at 2:55 p.m. a piece of paper was posted on the room side of the closed bathroom door. It was titled, Bowel and Bladder Schedule with a date range of 8/18/14-8/24/14. This piece of paper	F 241	RECEIVED SEP 0 8 2014 Minnesota Dept of Health Mankato	9/20/14

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

Administrator 09/05/2014

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
	245548	A. BUILDING _____ B. WING _____	08/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(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 241	Continued From page 1 included the resident's name, date and time of elimination pattern. Documentation was observed as "incontinent large (Lg) bowel movement (BM)." During observation on 8/18/14, at 1:15 p.m. R34 was seated in a wheelchair in her room. A piece of paper title, Bowel and Bladder Schedule with a date range of 8/18/14-8/24/14 was observed taped onto the inside of the shared bathroom door. This piece of paper included the resident's name, date and time of elimination pattern. Documentation was observed as "incontinent large (Lg) bowel movement" and also contained information related to the resident's foley catheter. This paper was visible to the resident sharing the bathroom and the public, including any visitor or staff . In subsequent observations throughout the survey on 8/18, at 5:00 p.m. on 8/19, at 11:00 a.m. on 8/20, at 1:00 p.m. and on 8/21/14, at 9:00 a.m. the same piece of paper was observed in R3 & R34's rooms with additional documentation related to elimination patterns (voiding/bowel movements). During an interview with director of nursing (DON) on 8/21/14, at 10:15 a.m. it was verified that toileting schedules and bowel and bladder status were routinely posted on the bathroom doors for most residents in the facility. DON also verified that additional residents (R1, R12 and R41) have similar information on the room side of the bathroom door that would be visible to any person entering the room including visitors. The DON further indicated that night staff post the bowel and bladder data collection sheets weekly.	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	08/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(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 309	Continued From page 2	F 309		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to document and monitor resident bruising for 2 of 3 residents (R27 & R38) who were reviewed for non-pressure related skin conditions. Findings include: R38 was prescribed Aspirin (ASA) 81 milligrams (mg) daily for a diagnosis of aortic valve disorder, which was noted on the care plan. R38 was assessed to have severe cognitive impairment according the the brief interview mental status (BIMS) dated 6/24/14. R38 was also assessed as a very high skin risk on all quarterly skin risk assessments for the past year. It was noted that on all quarterly skin risk assessments for the past year (12/31/13, 4/1/14 & 7/1/14), documentation was lacking related to any bruising. Documentation in the record indicated R38 was to wear derma saver sleeves on both arms but she had refused to wear the protective sleeves During record review, documentation was lacking to indicate R38 had	F 309	RECEIVED SEP 0 8 2014 Minnesota Dept of Health Mankato	9/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	08/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(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 309	Continued From page 3 experienced any bruising since 2013 according to the skin assessments. The care plan dated 7/8/14 indicated R38 had skin impairment evidenced by arms with discolored areas. The identified goal indicated: will have no further bruising. The care plan approaches were listed as: (1) watch for bruising due to use of ASA; and (2) chronic bruised/discolored looking areas to bilateral arms and legs that come and go, which includes areas on left forearm and left elbow. R38 was observed on 8/18/2014, at 4:11 p.m. to have two bruises on the left arm and one bruise by the elbow, both dark purple in color. R38 was again observed on 8/20/14, at 2:00 p.m. accompanied by the director of nursing (DON). The DON verified the bruised areas and measured as noted: the bruise on the left elbow was 3 centimeters (cm) x 2.5 cm and dark purple in color and the left forearm had two dark purple bruises-one measuring 4.5 cm x 2 cm and another located just below it measuring 0.75 cm x 2.5 cm. Licensed practical nurse (LPN)-A was interviewed on 8/19/14, at 2:50 p.m. and stated that if a resident has chronic bruises, they will not document each of the bruises. She indicated the nursing assistants (NA) were expected to report any new skin conditions to the nurse and the nurse will then fill out an incident report to notify personnel of the new bruise so that further investigation can be completed. LPN-A verified there was no documentation of any bruising since 2013 in the record of R38. On 8/20/14, at 12:30 p.m. the DON was	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	08/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(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 309	Continued From page 4 interviewed regarding the expectation of documenting skin abnormalities. The DON stated that she expected a nurse to document any bruise by color and size by filling out an incident report. The DON also stated R38 almost always has a bruised area located on the left arm and elbow which changes shades of purple. The DON verified there was no system to track and/or determine the cause of the bruising noted on R38's skin as the record lacked documentation which described the location and size of the bruised area. On 8/21/14, at 9:00 a.m. registered nurse (RN)-A stated the CNA's are directed to notify licensed staff of any new skin conditions. RN-A also stated that chronic bruising should be documented on the quarterly skin assessments and verified there was no documentation of the size or characteristics of the bruising as noted on R38's left arm. RN-A also verified that she would not be able to determine whether the identified bruises had notable changes due to the lack of documentation. During observation on 8/18/14, at 3:54 p.m. R27 was noted to have two large bruises on the right arm, one located below the elbow and purple colored and one located above the elbow and yellowish/green in color. During the observation R27 was interviewed and indicated she obtained the bruises from a recent fall. Review of R27's incident reports revealed the resident had 2 falls documented on 8/10/14 and on fall documented on 8/13/14. Review of nursing notes dated from 8/10/14 to 8/19/14 failed to identify any resident bruising. Interview with nursing assistant (NA)-A on 8/20/14, at 7:05 a.m. indicated she was aware of R27's current bruises and indicated they were	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	08/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(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 309	Continued From page 5 evident after a recent fall. NA-A further revealed she had not reported the resident bruising to the licensed nursing staff. Interview with the director of nursing (DON) on 8/20/14, at 3:05 p.m. confirmed there had been no investigation conducted related to R27's bruises on her right arm. The DON also indicated the bruises should have been monitored after they were noted. Subsequent to the interview, the DON measured the bruises and noted the following: the bruise below the elbow measured 4.0 cm (centimeters) width by 6.0 cm length and the bruise located above the elbow measured 5.5 cm in width by 7.0 cm in length The facility's policy and procedure titled, Skin Care Policy dated 7/30/2013 was reviewed. It indicated it is the responsibility of the DON, charge nurse and Minimum Data Set (MDS) coordinators to be aware of skin conditions that exist in the resident population. Under number one of the procedure, it instructs to report skin conditions, including bruises, to the charge nurse by the direct care staff.	F 309		

TO: Maria King, Minnesota Department of Health

RE: Tuff Memorial Home, Hills, MN: Plan of Correction

From: Dana Dahlquist, Administrator

The following measures have been identified to correct this deficiency:

F 241 483.15(a) Dignity and Respect of Individuality

1. We will initially report bruising by writing an incident report in Risk Management section of the computer and an investigation will be conducted.
2. Chronic bruising will be tracked quarterly in the Assessment Area in the computer with the quarterly MDS.
3. We will educate professional staff on reporting and documenting any resident bruising.
4. The Director of Nursing and the MDS Coordinators will monitor this.
5. We will be in compliance by September 20, 2014.

F 309 483.25 Provide Care/Service for Highest Well Being

1. We will remove personal care information from resident's bathroom doors.
2. We will add personal care information to the daily nurse aide assignment sheets.
3. We will keep nurse aide daily assignment sheets updated with personal care information.
4. We will provide education to nursing staff on these changes.
5. The Director of Nursing and the Quality Assurance Coordinator will monitor these changes.
6. We will be in compliance by September 20, 2014.

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

F5548023

PRINTED: 08/28/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/20/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	**505 EAST 4TH STREET HILLS, MN 56138**

(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 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF 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 Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Tuff Memorial Home was found to be not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or By e-mail to: Marian.Whitney@state.mn.us	K 000	PoCok FB 9-9-14 RECEIVED SEP 5 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

EXIT: 8-31-14 DC: 9-30-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dan Dahlquist — TITLE: Administrator — (X6) DATE: 09/05/2014

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.

TO: Patrick Sheehan, Supervisor Health Care Fire Inspections

RE: Tuff Memorial Home, Hills, MN: Plan of Correction

The following measures have been identified to correct these deficiencies:

K 038 NFPA101 Life Safety Code Standard

1. The Northwest exit door will be replaced by a local contractor.
2. The Administrator and Maintenance Supervisor will monitor this for compliance.
3. We will be in compliance by November 2, 2014.

K 052 NFPA 110 Life Safety Code Standard

1. We will contact local phone company and have two lines installed for the fire alarm dialer and the company that installed the fire alarm panel will make the necessary connections to the dialer.
2. The system will be tested to determine that the dialer is working properly.
3. The Maintenance Supervisor and the Administrator will monitor this for compliance.
4. We will be in compliance by November 2, 2014.

K 144 NFPA 110 Life Safety Code Standard

1. The Maintenance Supervisor will keep a weekly inspection log for the diesel emergency generator and give a copy to the administrator on a monthly basis of that report.
2. The Maintenance Supervisor and the Administrator will monitor this for compliance.
3. We will be in compliance by November 2, 2014.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/20/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	**505 EAST 4TH STREET** **HILLS, MN 56138**

(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 000	Continued From page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Tuff Memorial Home was constructed as follows: The original building was constructed in 1959, is one-story, has a partial basement, is fully fire sprinkler protected and is of Type II(111) construction; The 1st Addition was constructed in 1962, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 2nd Addition was constructed in 1975, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 3rd Addition was constructed in 1988, is one-story, has a full basement, is fully fire sprinkler protected and is of Type V(111) construction; The 4th Addition was constructed in 1998, is one-story, has no basement, is fully fire sprinkler protected and is of Type V(000) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. There are two-hour fire walls equipped with labeled 90-minute fire door assemblies, separating the buildings of Type	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/20/2014**

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TUFF MEMORIAL HOME	**505 EAST 4TH STREET HILLS, MN 56138**

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K 000	Continued From page 2 II(111) construction from the additions of Type V(000) construction. The facility has a capacity of 50 beds and had a census of 50 at time of the survey. Because the original building and the four additions met the construction types allowed for existing buildings, the facility was surveyed as one building, and one (1) Form CMS-2786R booklet was completed. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to provide means of egress in accordance with the following requirements of 2000 NFPA 101, Section 19.2., and 7.2.1.4.5. The deficient practice could affect 15 out of 50 residents. Findings include: On facility tour between 7:45 AM and 11:15 AM on 08/20/2014, observation revealed, that the Northwest exit discharge door takes more than 50 lbs of force to open. The hinge side of the door frame is cracked and the threshold is loose.	K 038		

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	245548	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/20/2014

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K 038	Continued From page 3 This deficient practice was confirmed by the Facility Maintenance Director (SV) at the time of discovery.	K 038		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to test the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72 Table 7-2.2 (16) (b). This could effect all 50 residents. Findings include: On facility tour between 7:45 AM and 11:15 AM on 08/20/2014, observation revealed the following: 1. Testing of the primary transmission line by	K 052		

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K 052	Continued From page 4 unplugging the phone line revealed, that there was no trouble signal with-in 4 minutes to the premises fire alarm system and monitoring company. 2. It could not be confirmed that the facility has two phone lines for the fire alarm dialer This deficient practice was confirmed by the Facility Maintenance Director (SV) at the time of discovery.	K 052		
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6-4.1. The deficient practice could affect all 50 residents. Findings include: On facility tour between 7:45 AM and 11:15 AM on 08/20/2014, documentation review of the	K 144		

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	245548	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/20/2014**

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K 144	Continued From page 5 weekly inspection logs (August 2013 to August 2014) for the diesel emergency generator revealed that the weekly operational inspection were missed for the week of 10/14/2013. This deficient practice was confirmed by the Facility Maintenance Director (SV) at the time of discovery *TEAM COMPOSITION* Kimberly Swenson, Life Safety Code Spc.	K 144		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3051 2835

August 28, 2014

Mr. Dana Dahlquist, Administrator
Tuff Memorial Home
505 East 4th Street
Hills, MN 56138

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5548023

Dear Mr. Dahlquist:

The above facility was surveyed on August 18, 2014 through August 21, 2014 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:

Maria King, Assistant Program Manager
Minnesota Department of Health
12 Civic Center, Plaza Suite #2105
Mankato, Minnesota 56001
Telephone: (507) 344-2716
Fax: (507) 344-2723

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,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

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
	00576	A. BUILDING: _____ B. WING _____	08/21/2014

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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: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000	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.	

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 8/18/14-8/21/14 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. 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.	2 000	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 which 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.	

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
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 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 document and monitor resident bruising for 2 of 3 residents (R27 & R38) who were reviewed for non-pressure related skin conditions. Findings include: R38 was prescribed Aspirin (ASA) 81 milligrams (mg) daily for a diagnosis of aortic valve disorder, which was noted on the care plan. R38 was assessed to have severe cognitive impairment according the the brief interview	2 830		

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2 830	Continued From page 3 mental status (BIMS) dated 6/24/14. R38 was also assessed as a very high skin risk on all quarterly skin risk assessments for the past year. It was noted that on all quarterly skin risk assessments for the past year (12/31/13, 4/1/14 & 7/1/14), documentation was lacking related to any bruising. Documentation in the record indicated R38 was to wear derma saver sleeves on both arms but she had refused to wear the protective sleeves During record review, documentation was lacking to indicate R38 had experienced any bruising since 2013 according to the skin assessments. The care plan dated 7/8/14 indicated R38 had skin impairment evidenced by arms with discolored areas. The identified goal indicated: will have no further bruising. The care plan approaches were listed as: (1) watch for bruising due to use of ASA; and (2) chronic bruised/discolored looking areas to bilateral arms and legs that come and go, which includes areas on left forearm and left elbow. R38 was observed on 8/18/2014, at 4:11 p.m. to have two bruises on the left arm and one bruise by the elbow, both dark purple in color. R38 was again observed on 8/20/14, at 2:00 p.m. accompanied by the director of nursing (DON). The DON verified the bruised areas and measured as noted: the bruise on the left elbow was 3 centimeters (cm) x 2.5 cm and dark purple in color and the left forearm had two dark purple bruises-one measuring 4.5 cm x 2 cm and another located just below it measuring 0.75 cm x 2.5 cm. Licensed practical nurse (LPN)-A was interviewed on 8/19/14, at 2:50 p.m. and stated that if a resident has chronic bruises, they will not	2 830		

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2 830	Continued From page 4 document each of the bruises. She indicated the nursing assistants (NA) were expected to report any new skin conditions to the nurse and the nurse will then fill out an incident report to notify personnel of the new bruise so that further investigation can be completed. LPN-A verified there was no documentation of any bruising since 2013 in the record of R38. On 8/20/14, at 12:30 p.m. the DON was interviewed regarding the expectation of documenting skin abnormalities. The DON stated that she expected a nurse to document any bruise by color and size by filling out an incident report. The DON also stated R38 almost always has a bruised area located on the left arm and elbow which changes shades of purple. The DON verified there was no system to track and/or determine the cause of the bruising noted on R38's skin as the record lacked documentation which described the location and size of the bruised area. On 8/21/14, at 9:00 a.m. registered nurse (RN)-A stated the CNA's are directed to notify licensed staff of any new skin conditions. RN-A also stated that chronic bruising should be documented on the quarterly skin assessments and verified there was no documentation of the size or characteristics of the bruising as noted on R38's left arm. RN-A also verified that she would not be able to determine whether the identified bruises had notable changes due to the lack of documentation. During observation on 8/18/14, at 3:54 p.m. R27 was noted to have two large bruises on the right arm, one located below the elbow and purple colored and one located above the elbow and yellowish/green in color. During the observation	2 830		

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2 830	Continued From page 5 R27 was interviewed and indicated she obtained the bruises from a recent fall. Review of R27's incident reports revealed the resident had 2 falls documented on 8/10/14 and on fall documented on 8/13/14. Review of nursing notes dated from 8/10/14 to 8/19/14 failed to identify any resident bruising. Interview with nursing assistant (NA)-A on 8/20/14, at 7:05 a.m. indicated she was aware of R27's current bruises and indicated they were evident after a recent fall. NA-A further revealed she had not reported the resident bruising to the licensed nursing staff. Interview with the director of nursing (DON) on 8/20/14, at 3:05 p.m. confirmed there had been no investigation conducted related to R27's bruises on her right arm. The DON also indicated the bruises should have been monitored after they were noted. Subsequent to the interview, the DON measured the bruises and noted the following: the bruise below the elbow measured 4.0 cm (centimeters) width by 6.0 cm length and the bruise located above the elbow measured 5.5 cm in width by 7.0 cm in length The facility's policy and procedure titled, Skin Care Policy dated 7/30/2013 was reviewed. It indicated it is the responsibility of the DON, charge nurse and Minimum Data Set (MDS) coordinators to be aware of skin conditions that exist in the resident population. Under number one of the procedure, it instructs to report skin conditions, including bruises, to the charge nurse by the direct care staff. SUGGESTED METHOD OF CORRECTION: The DON or designee could re-educate staff to document new skin abnormalities and monitor these on a regular basis for comparison. The designee could perform audits to ensure compliance.	2 830		

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2 830	Continued From page 6 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, document review and interview the facility failed to ensure that residents were treated in a dignified manner for 2 of 3 residents (R3 and R34) plus additional residents (R1, R12 and R41) who had personal care information posted on the bathroom door visible to the public. Findings include: During resident observation of R3 on 8/18/14, at 2:55 p.m. a piece of paper was posted on the room side of the closed bathroom door. It was titled, Bowel and Bladder Schedule with a date range of 8/18/14-8/24/14. This piece of paper included the resident's name, date and time of elimination pattern. Documentation was observed as "incontinent large (Lg) bowel movement (BM)." During observation on 8/18/14, at 1:15 p.m. R34 was seated in a wheelchair in her room. A piece of paper title, Bowel and Bladder Schedule with a	21805		

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TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

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21805	Continued From page 7 date range of 8/18/14-8/24/14 was observed taped onto the inside of the shared bathroom door. This piece of paper included the resident's name, date and time of elimination pattern. Documentation was observed as "incontinent large (Lg) bowel movement" and also contained information related to the resident's foley catheter. This paper was visible to the resident sharing the bathroom and the public, including any visitor or staff . In subsequent observations throughout the survey on 8/18, at 5:00 p.m. on 8/19, at 11:00 a.m. on 8/20, at 1:00 p.m. and on 8/21/14, at 9:00 a.m. the same piece of paper was observed in R3 & R34's rooms with additional documentation related to elimination patterns (voiding/bowel movements). During an interview with director of nursing (DON) on 8/21/14, at 10:15 a.m. it was verified that toileting schedules and bowel and bladder status were routinely posted on the bathroom doors for most residents in the facility. DON also verified that additional residents (R1, R12 and R41) have similar information on the room side of the bathroom door that would be visible to any person entering the room including visitors. The DON further indicated that night staff post the bowel and bladder data collection sheets weekly. SUGGESTED METHOD OF CORRECTION: The DON or designee could come up with a different system for documentation of personal resident information so that it is not visible to the public. An audit could be developed and reported to the quality assurance committee to ensure that privacy is maintained for all residents. TIME PERIOD FOR CORRECTION: Twenty-one	21805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00576	A. BUILDING: _____ B. WING _____	08/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	**505 EAST 4TH STREET HILLS, MN 56138**

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21805	Continued From page 8 (21) days.	21805		