DEPARTMENT OF HEALTH A	ND HUMA	N SERVICES			CENTERS FOR MEE	DICARE & MEDICAID SERVICES		
					AND TRANSMITTAL	ID: MHTT		
	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AGENCY	Facility ID: 00576		
1. MEDICARE/MEDICAID PROVIDER N	0.	3. NAME AND AL (L3)	DRESS OF FAC	CILITY		4. TYPE OF ACTION: <u>7 (</u> L8)		
(L1) 245548 2.STATE VENDOR OR MEDICAID NO.		TUFF ME	MORIAL	HOME 5	505 EAST	1. Initial 2. Recertification		
(L2) 230743000		^(L4) 4TH STR (L5) HILLS, M			(L6) 56138	3. Termination4. CHOW5. Validation6. Complaint		
5. EFFECTIVE DATE CHANGE OF OWN	JERSHIP	7. PROVIDER/SU		JORY	<u>02</u> (L7)	7. On-Site Visit 9. Other		
(L9)		01 Hospital 05 HHA 09 ES			13 PTIP 22 CLIA	8. Full Survey After Complaint		
6. DATE OF SURVEY 11/03/201	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FIGURE VEAD ENDING DATE: (1.25)			
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/III		FISCAL YEAR ENDING DATE: (L35)		
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30		
11. LTC PERIOD OF CERTIFICATION		10.THE FACILITY	' IS CERTIFIED	AS:		·		
From (a):		X A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirements:		
To (b):			equirements		2. Technical Personnel	6. Scope of Services Limit		
12.Total Facility Beds	50 (L18)	-	e Based On: cceptable POC		3. 24 Hour RN7. Medical Director 4. 7-Day RN (Rural SNF) 8. Patient Room Size			
12. Total Pacifity Beus	50 (L18)	1. A	cceptable POC		5. Life Safety Code	 F)8. Patient Room Size 9. Beds/Room 		
13.Total Certified Beds	50 (L17)		pliance with Prog ents and/or Appli		* Code: A	(L12)		
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
50	19 5141	ici	IID		1801 (c) (1) 01 1801 (j) (1).	(210)		
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARK	S (IF APPLICA	ABLE SHOW LTC CA	NCELLATION	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:		
Kimberly Swenson, Deputy St	tate Fire M	arshall 1	1/13/2014	(L19)	Kamala Fiske-Downing, Enforcement Specialist 11/14/2014 (L20			
PART 1	II - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	L OFFICE OR SINGLE S			
19. DETERMINATION OF ELIGIBILITY		20. COM	PLIANCE WITH	H CIVIL	21. 1. Statement of Finar	ncial Solvency (HCFA-2572)		
X 1. Facility is Eligible to Partici	inate	RIGH	ITS ACT:		 Ownership/Control Both of the Above 	ol Interest Disclosure Stmt (HCFA-1513)		
2. Facility is not Eligible	-F				5. bout of the Above :			
	(L21)							
22. ORIGINAL DATE 23	B. LTC AGREE	MENT 24	I. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY00	INVOLUNTARY		
03/01/1991					01-Merger, Closure	05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse			
25. LTC EXTENSION DATE: 27.	. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	n <u>OTHER</u>		
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change		
(L27)	B Rescind S	uspension Date:	(L44)			00-Active		
	D. Resente S	aspension Date.	(L45)					
28. TERMINATION DATE:	20). INTERMEDIARY/			30. REMARKS			
26. TERMINATION DATE.	23		CARRIER NO.		JU. REMARKS			
	(L28)	03001		(L31)				
	(120)			(1.01)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE				
,	(L32)	09/17/2014		(L33)	DETERMINATION APPI	ROVAL		



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,

Kumalu 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



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.

Tuff Memorial Home November 13, 2014 Page 2

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,

Kumalu 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

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 245548	(Y2) Multiple Construction A. Building B. Wing 01 - MAIN	BUILDING 01	(Y3) Date of Revisit 11/3/2014
Name of Facility	s	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	()	(5)	Date
		Correction			Correction				Correction
ID Prefix		Completed 11/03/2014	ID Prefix		Completed 11/03/2014	ID Prefix			Completed 11/03/2014
•	NFPA 101		0	NFPA 101		Reg. #	NFPA 101		
LSC	K0038	-	LSC	K0052		LSC	K0144		
		Correction			Correction				Correction
ID Des fiss		Completed	ID Day (b)		Completed	ID Desfec			Completed
		-							
Reg. # LSC			Reg. # LSC			Reg. # LSC			
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix		-	ID Prefix				. <u> </u>		
Reg. # LSC		-	Reg. # LSC			Reg. # LSC			
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix		-	ID Prefix						
Reg. #		_	Reg. #			Reg. #			
LSC			LSC			LSC			
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix			Completed
Reg. #			Reg. #			Reg. #			
LSC									
Reviewed I	By Reviewed	I By	Date:	Signature of Sur	veyor:			Date:	
State Agen	State Agency PS/KFD		11/13/20	/13/2014 34764				11/03/2014	
Reviewed I CMS RO	3y Reviewed	І Ву	Date:	Signature of Su	veyor:			Date:	
	o Survey Completed or	ו:		Check for any Unco	rrected Defic	iencies Was a	Summary of		
	8/20/2014			Uncorrected Defic				YES	NO

DEPARTMENT OF HEALTH	AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES			
					AND TRANSMITTAL	ID: MHTT			
1. MEDICARE/MEDICAID PROVIDER		3. NAME AND AI			TE SURVEY AGENCY	Facility ID: 00576 4. TYPE OF ACTION: 7 (L8)			
(L1) 245548	NO.	(L3) TUFF MEM				4. Integration 1. Initial 2. Recertification 3. Termination 4. CHOW			
2.STATE VENDOR OR MEDICAID NO.		(L4) 505 EAST 4	TH STREET						
(L2) 230743000		(L5) HILLS, MN			(L6) 56138	5. Validation 6. Complaint 7. On-Site Visit 9. Other			
5. EFFECTIVE DATE CHANGE OF OW (L9)	NERSHIP	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESI		ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint			
6. DATE OF SURVEY 10/03/20) 14 (L34)	01 Hospital 02 SNF/NF/Dual	05 HHA 06 PRTF	09 ESKD 10 NF	13 PHP 22 CLIA				
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/III		FISCAL YEAR ENDING DATE: (L35)			
0 Unaccredited 1 TJC		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30			
2 AOA 3 Other									
11. LTC PERIOD OF CERTIFICATION		10.THE FACILITY		AS:	And/On Annuousd Weissens Of	The Following Dequirements:			
From (a):		A. In Complia Program R	equirements		2. Technical Personnel	The Following Requirements: 6. Scope of Services Limit			
To (b):			e Based On:						
12. Total Facility Beds	50 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN				
13.Total Certified Beds	50 (L17)	X B. Not in Con			5. Life Safety Code	9. Beds/Room			
		Requirem	ents and/or Appli	ed Waivers:	* Code: B	(L12)			
14. LTC CERTIFIED BED BREAKDOWN	V				15. FACILITY MEETS				
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)			
50									
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REMAR	KS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION I	DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:			
Kathryn Serie, U	nit Supervise	or 1	0/21/2014		Kamala Fiske-Downing, Enforcement Specialist 10/22/2014				
PART	'II - TO BE (COMPLETED I	BY HCFA RE	(L19)	L OFFICE OR SINGLE S	L (L20)			
19. DETERMINATION OF ELIGIBILIT			IPLIANCE WITH			ncial Solvency (HCFA-2572)			
			ITS ACT:	TEIVIL	2. Ownership/Contro	ol Interest Disclosure Stmt (HCFA-1513)			
 X 1. Facility is Eligible to Parti 2. Facility is not Eligible 	cipate				3. Both of the Above	2: 			
2. Pacinty is not Englote	(L21)								
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	1ENT	26. TERMINATION ACTION	: (L30)			
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	ГЕ	VOLUNTARY 00	INVOLUNTARY			
03/01/1991					01-Merger, Closure	05-Fail to Meet Health/Safety			
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs				
25. LTC EXTENSION DATE: 2	7. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER			
	A. Suspension	n of Admissions:	T 40		04-Other Reason for withdrawai	07-Provider Status Change 00-Active			
(L27)	B. Rescind Su	uspension Date:	(L44)			00-10110			
			(L45)						
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS				
		03001							
	(L28)			(L31)					
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE					
	(L32)	09/17/2014		(L33)	DETERMINATION APP	ROVAL			



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

Tuff Memorial Home October 21, 2014 Page 2

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.

Tuff Memorial Home October 21, 2014 Page 3

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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,

Kumala 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

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.

) í	Provider / Supplier / CLIA / dentification Number 45548	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 10/3/2014
Name o	f Facility		Street Address, City, State, Zip Code	
TUFI	F 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	Correction Completed 09/20/2014	ID Prefix	F0309	Correction Completed 09/20/2014	ID Prefix		Correction Completed
	483.15(a)		Reg. # LSC	483.25	-	Reg. # LSC		
ID Prefix Reg. # LSC			Reg. #			Bog #		
Reg. #			Reg. #		Correction Completed			
Reg. #			Reg. #		Correction Completed	Reg. #		
ID Prefix Reg. # LSC			Reg. #			_		
Reviewed E	By Re	viewed By	Date:	Signature of Su	rveyor:		Date	:
State Agen Reviewed E CMS RO		S/KFD viewed By	10/21/201 Date:	4 Signature of Su	<u>03048</u> rveyor:	,	Date	10/03/2014 ::
Followup t	o Survey Comple 8/21/20			Check for any Unco Uncorrected Defi				S NO

DEPARTMENT ()F HEALTH						DICARE & MEDICAID SERVICES		
						AND TRANSMITTAL TE SURVEY AGENCY	ID: MHTT		
						IE SUKVEI AGENCI	Facility ID: 00576		
1. MEDICARE/MEDIC (L1) 245548	AID PROVIDER	NO.	3. NAME AND AI (L3) TUFF MEM				4. TYPE OF ACTION: $2(L8)$		
2.STATE VENDOR OR	MEDICAID NO		(L4) 505 EAST 4	TH STREET			1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. O. Str. VE. The one of the strength of the stre		
(L2) 230743000			(L5) HILLS, MN	,		(L6) 56138			
5. EFFECTIVE DATE ((L9)	CHANGE OF OV	VNERSHIP	7. PROVIDER/SU			<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint		
6. DATE OF SURVEY	08/21/2	014 (L34)	01 Hospital 02 SNF/NF/Dual	05 HHA 06 PRTF	09 ESRD 10 NF	13 PTIP 22 CLIA 14 CORF			
8. ACCREDITATION S		(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/III	FISCAL YEAR ENDING DATE: (
0 Unaccredited 2 AOA	1 TJC 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30		
11LTC PERIOD OF C					4.6.				
From (a):	ENTIFICATION		10.THE FACILITY A. In Complia		A5:	And/Or Approved Waivers Of	f The Following Requirements:		
To (b) :			-	equirements		2. Technical Personnel			
		FO (110)	*	e Based On:		3. 24 Hour RN	7. Medical Director		
12.Total Facility Beds		50 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SI 5. Life Safety Code	NF)8. Patient Room Size 9. Beds/Room		
13.Total Certified Beds		50 (L17)	X B. Not in Cor Requirem	npliance with Prog ents and/or Appli	gram ied Waivers:	* Code: B *	(L12)		
14. LTC CERTIFIED BI	ED BREAKDOW	N	1			15. FACILITY MEETS			
18 SNF	18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
	50								
(L37)	(L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY A	GENCY REMAR	RKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION	DATE):				
17. SURVEYOR SIGN	ATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL Date:		
T. J. T. b 1	UPP NE H		(9/12/2014					
<u> </u>	HFE NE II			,,, 12, 2011	(L19)	Kamala Fiske-Downing. Enforcement Specialist ^{09/15/2014} (L20)			
	PAR	TII - TO BE	COMPLETED	BY HCFA RI	EGIONA	L OFFICE OR SINGLE S	STATE AGENCY		
19. DETERMINATION	N OF ELIGIBILIT	Ϋ́Υ		IPLIANCE WIT	H CIVIL		ancial Solvency (HCFA-2572)		
1. Facility	is Eligible to Part	ticipate	RIGI	HTS ACT:		 Ownership/Contr Both of the Abov 	rol Interest Disclosure Stmt (HCFA-1513) re :		
2. Facilit	y is not Eligible	(L21)							
		(121)							
22. ORIGINAL DATE		23. LTC AGREEN	MENT 2	4. LTC AGREEN	MENT	26. TERMINATION ACTION	I: (L30)		
OF PARTICIPATIC	DN	BEGINNINC	5 DATE	ENDING DA	TE	<u>VOLUNTARY</u> <u>0</u>			
03/01/1991		(1.41)		(1.05)		01-Merger, Closure 02-Dissatisfaction W/ Reimburg	05-Fail to Meet Health/Safety sement 06-Fail to Meet Agreement		
(L24) 25. LTC EXTENSION	DATE:	(L41)	VE SANCTIONS	(L25)		03-Risk of Involuntary Terminati	on		
25. LIC EXTENSION	DATE:		of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change		
	(1.07)	1		(L44)			00-Active		
	(L27)	B. Rescind Su	spension Date:						
				(L45)					
28. TERMINATION D	ATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS			
			03001						
		(L28)			(L31)				
31. RO RECEIPT OF C	MS-1539	32	. DETERMINATION	I OF APPROVAI	LDATE				
		(1.22)			(1.22)				
		(L32)			(L33)	DETERMINATION APP	KUVAL		



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;

Tuff Memorial Home August 28, 2014 Page 3

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- 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

Tuff Memorial Home August 28, 2014 Page 5

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,

Kumalu 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

	RS FOR MEDICARE	& MEDICAID SERVICES	r		OMB NO. 0938-039		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245548	B. WING		08/21/2014		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
TUFF ME	MORIAL HOME		1	505 EAST 4TH STREET HILLS, MN 56138			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLÉTIC		
F 000	INITIAL COMMEN	rs	F 000				
	as your allegation of Department's acce	of correction (POC) will serve of compliance upon the ptance. Your signature at the page of the CMS-2567 form will tion of compliance.					
F 241 SS=E	revisit of your facilit validate that substa regulations has bee your verification.	acceptable POC an on-site y may be conducted to antial compliance with the en attained in accordance with Y AND RESPECT OF	F 24	1			
	manner and in an e enhances each res	omote care for residents in a environment that maintains or ident's dignity and respect in is or her individuality.			9/201		
	by: Based on observation interview the facility were treated in a di residents (R3 and F (R1, R12 and R41)	NT is not met as evidenced tion, document review and a failed to ensure that residents ignified manner for 2 of 3 R34) plus additional residents who had personal care on the bathroom door visible	ou more flatted	RECEIVEL SEP 0 8 2014			
	2:55 p.m. a piece o room side of the clo titled, Bowel and Bl	servation of R3 on 8/18/14, at If paper was posted on the osed bathroom door. It was adder Schedule with a date 24/14. This piece of paper	<i>Bt</i>	Minnesota Dept of He Mankato	alth		

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.

PRINTED: 08/28/2014

		AND HUMAN SERVICES				FORM	08/28/201 APPROVE 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '		PLE CONSTRUCTION		E SURVEY IPLETED	
		245548	B. WING	÷		08/21/2014		
NAME OF	PROVIDER OR SUPPLIER	L	1		STREET ADDRESS, CITY, STATE, ZIP CODE	,		
TUFF ME	MORIAL 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)			- X }	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIO DATE	
F 241	included the reside elimination pattern observed as "incor movement (BM)." During observation was seated in a wh of paper title, Bowed date range of 8/18 taped onto the insi door. This piece of name, date and tim Documentation wa large (Lg) bowel me information related catheter. This pap sharing the bathron any visitor or staff In subsequent obs survey on 8/18, at a.m. on 8/20, at 1: 9:00 a.m. the same in R3 & R34's roor documentation rela- (voiding/bowel moi During an interview on 8/21/14, at 10:1 toileting schedules were routinely pos most residents in t that additional resi similar information bathroom door that entering the room further indicated th	ent's name, date and time of . Documentation was htinent large (Lg) bowel n on 8/18/14, at 1:15 p.m. R34 heelchair in her room. A piece el and Bladder Schedule with a /14-8/24/14 was observed de of the shared bathroom if paper included the resident's ne of elimination pattern. as observed as "incontinent hovement" and also contained it to the resident's foley ber was visible to the resident om and the public, including hervations throughout the 5:00 p.m. on 8/19, at 11:00 00 p.m. and on 8/21/14, at e piece of paper was observed ns with additional ated to elimination patterns		241	RECEIVED SEP 0 8 2014 Minnesota Dept of Health Mankato	7		

Facility ID: 00576

If continuation sheet Page 2 of 6

TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		245548			08/21/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
	EMORIAL HOME			505 EAST 4TH STREET HILLS, MN 56138	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE COMPLETIC
F 309	 Continued From page 2 483.25 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 		F 30 F 30		9/201
	conditions. Findings include: R38 was prescribe (mg) daily for a dia which was noted of R38 was assessed impairment accord mental status (BIM also assessed as a quarterly skin risk a It was noted that of assessments for th & 7/1/14), docume any bruising. Doct	d Aspirin (ASA) 81 milligrams gnosis of aortic valve disorder, in the care plan. to have severe cognitive ing the the brief interview S) dated 6/24/14. R38 was a very high skin risk on all assessments for the past year. In all quarterly skin risk is past year (12/31/13, 4/1/14 intation was lacking related to imentation in the record to wear derma saver sleeves		RECEIVE SEP 0 8 2014 Minnesota Dept of H Mankato	

Event ID: MHTT11

Facility ID: 00576

If continuation sheet Page 3 of 6

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l · ·		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245548	B. WING	i		08/2	21/2014
NAME OF F	PROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE		
TUFF ME	MORIAL HOME				505 EAST 4TH STREET		
			ID		HILLS, MN 56138	NI	0(5)
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	experienced any br the skin assessment The care plan dates skin impairment ev discolored areas. T will have no further approaches were li due to use of ASA; bruised/discolored and legs that come on left forearm and R38 was observed have two bruises o by the elbow, both again observed on accompanied by th The DON verified t measured as noted was 3 centimeters in color and the left bruises-one measu another located jus 2.5 cm.	d 7/8/14 indicated R38 had idenced by arms with 'he identified goal indicated: bruising. The care plan sted as: (1) watch for bruising and (2) chronic looking areas to bilateral arms and go, which includes areas left elbow. on 8/18/2014, at 4:11 p.m. to n the left arm and one bruise dark purple in color. R38 was 8/20/14, at 2:00 p.m. e director of nursing (DON). he bruised areas and d: the bruise on the left elbow (cm) x 2.5 cm and dark purple riorearm had two dark purple iring 4.5 cm x 2 cm and t below it measuring 0.75 cm x	F	309	ρ		
	on 8/19/14, at 2:50 resident has chroni document each of nursing assistants any new skin condi nurse will then fill o personnel of the ne investigation can b	nurse (LPN)-A was interviewed p.m. and stated that if a ic bruises, they will not the bruises. She indicated the (NA) were expected to report tions to the nurse and the out an incident report to notify ew bruise so that further e completed. LPN-A verified mentation of any bruising since of R38.			RECEIVED SEP 0 8 2014 Minnesota Dept of Hea Mankato		
	On 8/20/14, at 12:3	30 p.m. the DON was					

Event ID: MHTT11

Facility ID: 00576

If continuation sheet Page 4 of 6

PRINTED: 08/28/2014

		AND HUMAN SERVICES				FORM	08/28/2014 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245548	B. WING			08/;	21/2014
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
TUFF M	EMORIAL HOME				05 EAST 4TH STREET IILLS, MN 56138		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	interviewed regardi documenting skin a stated that she exp any bruise by color incident report. Th almost always has left arm and elbow purple. The DON we track and/or determ noted on R38's skin documentation white size of the bruised On 8/21/14, at 9:00 stated the CNA's an staff of any new ski stated that chronic documented on the and verified there we size or characterist R38's left arm. RN not be able to deter bruises had notable documentation. During observation was noted to have arm, one located by colored and one loc yellowish/green in or R27 was interviewed the bruises from a Review of R27's ind resident had 2 falls on fall documented nursing notes dated to identify any resid Interview with nursi 8/20/14, at 7:05 a.r	ng the expectation of abnormalities. The DON ected a nurse to document and size by filling out an the DON also stated R38 a bruised area located on the which changes shades of erified there was no system to hine the cause of the bruising in as the record lacked ch described the location and area. a.m. registered nurse (RN)-A re directed to notify licensed in conditions. RN-A also bruising should be e quarterly skin assessments vas no documentation of the ics of the bruising as noted on -A also verified that she would rmine whether the identified e changes due to the lack of on 8/18/14, at 3:54 p.m. R27 two large bruises on the right elow the elbow and purple cated above the elbow and color. During the observation ed and indicated she obtained recent fall. cident reports revealed the documented on 8/10/14 and on 8/13/14. Review of d from 8/10/14 to 8/19/14 failed	F3	809			

If continuation sheet Page 5 of 6

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245548	B. WING			08/	21/2014
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
TUFF ME	MORIAL HOME				05 EAST 4TH STREET IILLS, MN 56138		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	evident after a rece she had not reporte licensed nursing sta Interview with the d 8/20/14, at 3:05 p.r no investigation con bruises on her right the bruises should they were noted. So DON measured the following: the bruise 4.0 cm (centimeters the bruise located a cm in width by 7.0 o The facility's policy Care Policy dated 7 indicated it is the re charge nurse and N coordinators to be exist in the resident one of the procedu	ent fall. NA-A further revealed ed the resident bruising to the aff. lirector of nursing (DON) on n. confirmed there had been nducted related to R27's t arm. The DON also indicated have been monitored after ubsequent to the interview, the e bruises and noted the se below the elbow measured s) width by 6.0 cm length and above the elbow measured 5.5 cm in length and procedure titled, Skin 7/30/2013 was reviewed. It esponsibility of the DON, Minimum Data Set (MDS) aware of skin conditions that t population. Under number re, it instructs to report skin g bruises, to the charge nurse	F 3	309	RECEIVED SEP 0 8 2014 Minnesota Dept of Health Mankato		

Facility ID: 00576

If continuation sheet Page 6 of 6

PRINTED: 08/28/2014

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.

RECEIVED

SEP 0 8 2014

Minnesota Dept of Health Mankato

DEPARTMENT OF HEALTH AND HUMAN SERVICES

F5548023

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

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
		245548	B. WING		08/20/2014
				STREET ADDRESS, CITY, STATE, ZIP COD 505 EAST 4TH STREET HILLS, MN 56138	E
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLETION
K 000	INITIAL COMMEN	ſS	KO		
0-14	THE FACILITY'S P ALLEGATION OF (DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR TE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.		POCOK 789-9-14	
- 1- 1	ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS H/	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT IMPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.			
A N	Minnesota Departn Fire Marshal Divisio Tuff Memorial Hom substantial complia participation in Meo Subpart 483.70(a), 2000 edition of Nat	Survey was conducted by the nent of Public Safety, State on. At the time of this survey, was found to be not in ince with the requirements for dicare/Medicaid at 42 CFR, Life Safety from Fire, and the ional Fire Protection			
8.21	Chapter 19 Existing	R THE FIRE SAFETY		SEP 5 2014	
ENT	Health Care Fire In State Fire Marshal 445 Minnesota Stre St. Paul, MN 5510	Division eet, Suite 145		MN DEPT. OF PUBLIC SAFET STATE FIRE MARSHAL DIVIS	Y ON
		n.Whitney@state.mn.us			
	() in k	DER/SUPPLIER REPRESENTATIVE'S SIG huguit an asterisk (*) denotes a deficiency w		administratos	09/05/20

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.

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

CENTER	RS FOR MEDICAR	E & MEDICAID SERVICES			OMB NO. 0938-039		
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	NG 01 -	ONSTRUCTION MAIN BUILDING 01	CON	E SURVEY
		245548	B. WING		ET ADDRESS, CITY, STATE, ZIP CO		20/2014
		ę		505 E	AST 4TH STREET		
				HILL	S, MN 56138		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
K 000	Continued From page 1		ĸ	000			
	THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:						
	to correct the defin						
		proposed, completion date.					
	responsible for co	or title of the person rrection and monitoring to rence of the deficiency.					
	The original buildi one-story, has a p	me was constructed as follows: ng was constructed in 1959, is artial basement, is fully fire d and is of Type II(111)					
	The 1st Addition w one-story, has no protected and is o The 2nd Addition	vas constructed in 1962, is basement, is fully fire sprinkler f Type II(111) construction; was constructed in 1975, is					
	protected and is o The 3rd Addition v one-story, has a fi	basement, is fully fire sprinkler f Type II(111) construction; vas constructed in 1988, is ull basement, is fully fire d and is of Type V(111)					-
	one-story, has no	vas constructed in 1998, is basement, is fully fire sprinkler f Type V(000) construction.					
×	detection in the co corridors which is department notific walls equipped wi	fire alarm system with smoke prridors and spaces open to the monitored for automatic fire cation. There are two-hour fire th labeled 90-minute fire door rating the buildings of Type					

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	• •	TIPLE CONSTRUCTION			
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG 01 - MAIN BUILD	DING 01		
		245548	B. WING			08/	20/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, 505 EAST 4TH ST HILLS, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	C PROVI	DER'S PLAN OF CORREC DRRECTIVE ACTION SHO FERENCED TO THE APPP DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
	 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: 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 		к 0 ,				
	Based on observa provide means of e following requireme Section 19.2., and practice could affer Findings include: On facility tour betto on 08/20/2014, obs Northwest exit disc 50 lbs of force to o	is not met as evidenced by: tion, the facility failed to egress in accordance with the ents of 2000 NFPA 101, 7.2.1.4.5. The deficient ct 15 out of 50 residents. ween 7:45 AM and 11:15 AM servation revealed, that the charge door takes more than pen. The hinge side of the ked and the threshold is loose.			τ.	2	

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	E & MEDICAID SERVICES	· · · · ·			T	CUDVEV
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01		SURVEY PLETED
	245548	B. WING			08/2	20/2014
NAME OF PROVIDER OR SUPPLIER			50	TREET ADDRESS, CITY, STATE, ZIP CODE 05 EAST 4TH STREET IILLS, MN 56138		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 038 Continued From p	age 3	ĸ	038			
Facility Maintenan discovery.	tice was confirmed by the ce Director (SV) at the time of AFETY CODE STANDARD	к	052			
SS=F A fire alarm system installed, tested, a with NFPA 70 Nati 72. The system ha	n required for life safety is nd maintained in accordance onal Electrical Code and NFPA as an approved maintenance im complying with applicable				×	
This STANDARD Based on observa facility failed to tes accordance with t 101, Sections 19.	is not met as evidenced by: is not met as evidenced by: ation and staff interview, the st the fire alarm system in he requirements of 2000 NFPA 3.4.1 and 9.6, as well as 1999 2.2 (16) (b). This could effect					
Findings include: On facility tour be on 08/20/2014, of following:	tween 7:45 AM and 11:15 AM oservation revealed the					
1. Testing of the	primary transmission line by			notite ID: 00576	A	et Page 4 of

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00576

If continuation sheet P ag

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

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

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·		E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245548	B. WING			08/	20/2014
	PROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP CODE 105 EAST 4TH STREET 11LLS, MN 56138		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 052 K 144 SS=D	 was no trouble sign premises fire alarm company. 2. It could not be c two phone lines for This deficient pract Facility Maintenanc discovery. NFPA 101 LIFE SA Generators are insp 	ne line revealed, that there al with-in 4 minutes to the system and monitoring onfirmed that the facility has the fire alarm dialer ice was confirmed by the e Director (SV) at the time of FETY CODE STANDARD pected weekly and exercised inutes per month in		144			
	Based on documer interview, the facilit emergency general requirements of 200 NFPA 110 Chapter could affect all 50 m Findings include: On facility tour betw	veen 7:45 AM and 11:15 AM umentation review of the	1	Fa	cility ID: 00576	uation she	et Page 5 of 6

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	RS FOR MEDICARE	& MEDICAID SERVICES					0938-039
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION MAIN BUILDING 01	(X3) DAT COM	E SURVEY
		245548	B. WING			08/	20/2014
	PROVIDER OR SUPPLIER E MORIAL HOME			505 E	ET ADDRESS, CITY, STATE, ZIP COD AST 4TH STREET S, MN 56138	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
K 144	weekly inspection I 2014) for the diese revealed that the w were missed for th This deficient prac Facility Maintenand discovery	logs (August 2013 to August el emergency generator veekly operational inspection e week of 10/14/2013. tice was confirmed by the ce Director (SV) at the time of	K 1	44			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: MHTT21

Facility ID: 00576



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 <u>only a suggestion</u> 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

Tuff Memorial Home August 28, 2014 Page 2 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,

Kumalu 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 Tuff Memorial Home August 28, 2014 Page 3

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3) DATE SURVEY COMPLETED
		00576	B. WING		08/21/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
TUFF ME	EMORIAL HOME	505 EAST HILLS, MI	[•] 4TH STREE N 56138	T	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
2 000	Initial Comments		2 000		
	*****ATTE	NTION*****			
	NH LICENSING	CORRECTION ORDER			
	144A.10, this corre pursuant to a surve found that the defic herein are not corre not corrected shall	Minnesota Statute, section ction order has been issued by. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance fines promulgated by rule of artment of Health.			
	corrected requires requirements of the number and MN Ru When a rule contai comply with any of lack of compliance re-inspection with a result in the assess	hether a violation has been compliance with all a rule provided at the tag ule number indicated below. Ins several items, failure to the items will be considered a Lack of compliance upon any item of multi-part rule will sment of a fine even if the item uring the initial inspection was			
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.			
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s	o participate in the electronic nsure orders consistent with artment of Health tin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal softw Tag numbers have been assigned to Minnesota state statutes/rules for Nur Homes.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

STATEMEN	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		00576	B. WING		08/21/20)14
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
	EMORIAL HOME	505 EAST HILLS, MI	4TH STREE 56138	ET		
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2 000	Continued From pa	ge 1	2 000			
	Department of Hea you electronically. is necessary for Sta enter the word "cor text. You must then State licensure proc completion date, th corrected prior to e Minnesota Departm On 8/18/14-8/21/14 Department's staff, the following correct Please indicate in y correction that you and identify the data Minnesota Departm the State Licensing federal software. Ta assigned to Minnes Nursing Homes. The assigned tag n column entitled "ID statute/rule out of c "Summary Stateme and replaces the "T correction order. Th findings which are i after the statement evidence by." Follow are the Suggested Time period for Cor PLEASE DISREGA	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. 4 surveyors of this visited the above provider and tion orders are issued. Your electronic plan of have reviewed these orders, e when they will be completed. The the above been correction Orders using ag numbers have been sota state statutes/rules for umber appears in the far left of Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the his column also includes the n violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and trection. ARD THE HEADING OF THE WHICH STATES,		The assigned tag number appears far left column entitled "ID Prefix T The state statute/rule number and corresponding text of the state stat out of compliance is listed in the "Summary Statement of Deficienci column and replaces the "To Comp portion of the correction order. The column also includes the findings are in violation of the state statute statement, "This Rule is not met as evidenced by." Following the surve findings are the Suggested Method Correction and the Time Period For Correction. PLEASE DISREGARD THE HEAD THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES T FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION VIOLATIONS OF MINNESOTA ST STATUTES/RULES.	Tag." the tute/rule es" oly" his which after the s reyors d of or DING OF C THIS O THIS	
	APPLIES TO FEDE	N OF CORRECTION." THIS RAL DEFICIENCIES ONLY. R ON EACH PAGE.				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00576	B. WING		08/	21/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	MORIAL HOME		T 4TH STREET IN 56138	Г		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	ige 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830			
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the ain in bed or the resident bed.	ł			
	by: Based on observat review the facility fa resident bruising fo	ent is not met as evidenced ion, interview and document ailed to document and monitor r 2 of 3 residents (R27 & R38) I for non-pressure related skin				
	Findings include:					
		d Aspirin (ASA) 81 milligrams gnosis of aortic valve disorder, n the care plan.				
		to have severe cognitive ing the the brief interview				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00576	B. WING		08/	8/21/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
	EMORIAL HOME		T 4TH STREET IN 56138	Г			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 830	mental status (BIM also assessed as a quarterly skin risk a It was noted that of assessments for th & 7/1/14), docume any bruising. Docu indicated R38 was on both arms but s protective sleeves documentation was experienced any but the skin assessme The care plan date skin impairment ev discolored areas. T will have no further approaches were lid due to use of ASA; bruised/discolored and legs that come on left forearm and R38 was observed have two bruises o by the elbow, both again observed on accompanied by th The DON verified t measured as noted was 3 centimeters in color and the left bruises-one measu another located just	S) dated 6/24/14. R38 was a very high skin risk on all assessments for the past year. In all quarterly skin risk be past year (12/31/13, 4/1/14 Intation was lacking related to umentation in the record to wear derma saver sleeves he had refused to wear the During record review, is lacking to indicate R38 had ruising since 2013 according to nts. d 7/8/14 indicated R38 had idenced by arms with The identified goal indicated: bruising. The care plan isted as: (1) watch for bruising and (2) chronic looking areas to bilateral arms and go, which includes areas					
nnesota D	on 8/19/14, at 2:50	nurse (LPN)-A was interviewed p.m. and stated that if a ic bruises, they will not	1				

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00576	B. WING		08/	21/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
TUFF MI	EMORIAL HOME		T 4TH STREE IN 56138	Г		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	document each of t nursing assistants any new skin condi nurse will then fill o personnel of the ne investigation can be there was no docur 2013 in the record On 8/20/14, at 12:3 interviewed regardi documenting skin a stated that she exp any bruise by color incident report. Th almost always has left arm and elbow purple. The DON v track and/or determ noted on R38's skin	the bruises. She indicated the (NA) were expected to report tions to the nurse and the ut an incident report to notify w bruise so that further e completed. LPN-A verified mentation of any bruising since	2 830			
	stated the CNA's a staff of any new ski stated that chronic documented on the and verified there v size or characterist R38's left arm. RN not be able to deter bruises had notable documentation. During observation was noted to have arm, one located b	a.m. registered nurse (RN)-A re directed to notify licensed in conditions. RN-A also				

00576 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 SUMMARY STATEMENT OF DEFICIENCIES				CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
WHE OF PROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE YUFF MEMORIAL HOME SUBMARY STATEMENT OF DEFICIENCIES (M) ID PRETA TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY) PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH DEFICIENCY) (05) (2830 2 830 Continued From page 5 2 830 Review of R27's incident reports revealed the resident had 2 falls documented on 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 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, Interview with he 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 son 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 to report skin Care Policy dated 7/30/2013 was reviewed. It indicated it is 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 theses on a regular basis for comparison. The			00576	B. WING		00/04/0044	
S05 EAST 4TH STREET HILLS, MM 5013 OWHINE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECIDENCIES) (EACH DEFICIENCY MUST BE PRECIDENCIES) (EACH OPERCIENCY OR U.S. CIRENTFYING INFORMATION) DP PREFIX PAC PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY COMP CORSE-REFERENCE OT INFORMATION COMP CROSS-REFERENCE OT INFORMATION COMP CROSS-REFERENCE OT INFORMATION COMP CROSS-REFERENCE DEFICIENCY 2 830 Continued From page 5 2 830 2 830					TATE, ZIP CODE	00/	21/2014
HILLS, WM 56138 DWID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRÉCEDED BY PULL REQUATORY OR LSC IDENTIFYING INFORMATION) DI PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE to THE APROPRIATE DEFICIENCY) Comment Deficiency 2 830 Continued From page 5 2 830 2 830 Continued From page 5 2 830 R27 was interviewed and indicated she obtained the bruises from a recent fall. Review of R27's incident reports revealed the resident had 2 fails documented on 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 an. 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 bruise located box we neasured 4.0 cm (centimeters) width by 6.0 cm length and the bruise located above the elbow measured 4.0 cm (centimeters) width by 6.0 cm 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							
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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 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	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	ON SHOULD BE	COMPLET
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nesota Department of Health	nnesota De	the bruises from a Review of R27's incresident had 2 falls on fall documented nursing notes dated to identify any resid Interview with nursi 8/20/14, at 7:05 a.m R27's current bruis evident after a rece she had not reported licensed nursing sta Interview with the d 8/20/14, at 3:05 p.m no investigation cor bruises on her right the bruises should they were noted. So DON measured the following: the bruis 4.0 cm (centimeters the bruise located a cm in width by 7.0 c The facility's policy Care Policy dated 7 indicated it is the re charge nurse and N coordinators to be a exist in the resident one of the procedur conditions, includin by the direct care s SUGGESTED MET The DON or design document new skin these on a regular I designee could per compliance.	recent fall. cident reports revealed the documented on 8/10/14 and l on 8/13/14. Review of d from 8/10/14 to 8/19/14 failed lent bruising. ing assistant (NA)-A on n. indicated she was aware of es and indicated they were ent fall. NA-A further revealed ed the resident bruising to the aff. lirector of nursing (DON) on n. confirmed there had been nducted related to R27's t arm. The DON also indicated have been monitored after ubsequent to the interview, the e bruises and noted the se below the elbow measured s) width by 6.0 cm length and above the elbow measured 5.5 cm in length and procedure titled, Skin 7/30/2013 was reviewed. It esponsibility of the DON, Minimum Data Set (MDS) aware of skin conditions that t population. Under number re, it instructs to report skin g bruises, to the charge nurse taff.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/21/2014	
		00576	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
TUFF ME	EMORIAL HOME		T 4TH STREET IN 56138	r		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	ige 6	2 830			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a				
	by: Based on observation interview the facility were treated in a diresidents (R3 and F (R1, R12 and R41)	ent is not met as evidenced ion, document review and railed to ensure that residents gnified manner for 2 of 3 R34) plus additional residents who had personal care on the bathroom door visible	5			
	Findings include:					
	2:55 p.m. a piece o room side of the clo titled, Bowel and Bl range of 8/18/14-8/ included the reside elimination pattern.	servation of R3 on 8/18/14, at f paper was posted on the osed bathroom door. It was adder Schedule with a date 24/14. This piece of paper nt's name, date and time of Documentation was tinent large (Lg) bowel				
	was seated in a wh	on 8/18/14, at 1:15 p.m. R34 eelchair in her room. A piece I and Bladder Schedule with a				

Minnesota Department of He STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 08/21/2014	
		00576				
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
TUFF MI	EMORIAL HOME		T 4TH STREET IN 56138	T		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
21805	date range of 8/18/ taped onto the insid door. This piece of name, date and tim Documentation was large (Lg) bowel mainformation related catheter. This pape sharing the bathroot any visitor or staff. In subsequent obse survey on 8/18, at 9 a.m. on 8/20, at 1:0 9:00 a.m. the same in R3 & R34's room documentation relat (voiding/bowel mov During an interview on 8/21/14, at 10:15 toileting schedules were routinely post most residents in the that additional residents similar information bathroom door that entering the room in further indicated the and bladder data con SUGGESTED MET The DON or design different system for resident information public. An audit con	14-8/24/14 was observed de of the shared bathroom f paper included the resident's ne of elimination pattern. s observed as "incontinent ovement" and also contained to the resident's foley er was visible to the resident on and the public, including ervations throughout the 5:00 p.m. on 8/19, at 11:00 00 p.m. and on 8/21/14, at e piece of paper was observed as with additional ated to elimination patterns rements). with director of nursing (DON 5 a.m. it was verified that and bowel and bladder status ed on the bathroom doors for he facility. DON also verified dents (R1, R12 and R41) have on the room side of the twould be visible to any persor ncluding visitors. The DON at night staff post the bowel ollection sheets weekly.		DEFICIENC	YY)	

Minnesota Department of HealthSTATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPL IDENTIFICATION N			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. DOILDING.			
	00576	B. WING		08/	21/2014
IAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
UFF MEMORIAL HOME		ST 4TH STREET MN 56138	Г		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
21805 Continued From pa	age 8	21805			
(21) days.					