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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MMG6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00800

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245401**
2.STATE VENDOR OR MEDICAID NO.
(L2) **936540100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CENTRAL HEALTH CARE**
(L4) **444 NORTH CORDOVA**
(L5) **LE CENTER, MN** (L6) **56057**

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 **06/20/2014** (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 **54** (L18)

13.Total Certified Beds **54** (L17)

10.
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
	54			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Elizabeth Nelson, HFE NE II 06/20/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 06/24/2014 (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
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/20/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5401
The facility was not in substantial compliance with Federal participation requirements at the time of the standard survey completed on 05/08/14. On 06/20/14, the Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and on 06/02/14, the Department of Public Safety completed a PCR. Based on the PCR, it has been determined that the facility achieved substantial compliance pursuant to the standard survey completed on 05/08/14, effective 06/11/14. Refer to the CMS-2567b for both health and life safety code.

Effective 06/11/14, the facility is certified for 54 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5401

Electronically Delivered: June 24, 2014

Mr. Karl Pelovsky, Administrator
Central Health Care
444 North Cordova
Le Center, Minnesota 56057

Dear Mr. Pelovsky:

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 June 11, 2014, the above facility is certified for:

54 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 54 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

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 about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: June 20, 2014

Mr. Karl Pelovsky, Administrator
Central Health Care
444 North Cordova
Le Center, Minnesota 56057

RE: Project Number S5401023

Dear Mr. Pelovsky:

On May 23, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 8, 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 June 20, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 2, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 8, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 11, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 8, 2014, effective June 11, 2014 and therefore remedies outlined in our letter to you dated May 23, 2014, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Feel free to contact me if you have questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

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
245401	A. Building B. Wing	6/20/2014

Name of Facility	Street Address, City, State, Zip Code
CENTRAL HEALTH CARE	444 NORTH CORDOVA LE CENTER, MN 56057

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 **F0176** Reg. # **483.10(n)** LSC	Correction Completed **05/28/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **05/28/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **05/28/2014**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **06/11/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **05/28/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **05/28/2014**
ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **05/28/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **06/11/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **05/28/2014**
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

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GL/AK	06/20/2014	13603	06/20/2014
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
5/8/2014			

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
245401	A. Building 01 - MAIN BUILDING 01 B. Wing	6/2/2014

Name of Facility	Street Address, City, State, Zip Code
CENTRAL HEALTH CARE	444 NORTH CORDOVA LE CENTER, MN 56057

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 K0056	05/28/2014	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		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/AK	Date: 06/20/2014	Signature of Surveyor: 19251	Date: 06/02/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 5/6/2014		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: MMG6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00800

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245401**
2.STATE VENDOR OR MEDICAID NO.
(L2) **936540100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CENTRAL HEALTH CARE**
(L4) **444 NORTH CORDOVA**
(L5) **LE CENTER, MN** (L6) **56057**

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 **05/08/2014** (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 **54** (L18)

13.Total Certified Beds 54 (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
	54			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Elizabeth Nelson - NEII 06/20/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 06/20/2014 (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
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 06/20/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5401

At the time of the standard survey completed 05/08/14, the facility was not in substantial compliance and the most serious deficiencies 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 as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 23, 2014

Mr. Karl Pelovsky, Administrator
Central Health Care
444 North Cordova
Le Center, Minnesota 56057

RE: Project Number S5401023

Dear Mr. Pelovsky:

On May 8, 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:

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

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

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

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

<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:

Gayle Lantto, Supervisor
Metro D Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: gayle.lantto@state.mn.us

Phone: (651) 201-3794
Fax: (651) 201-3790

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 June 17, 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 June 17, 2014 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC 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 ePoC 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 ePoC 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 ePoC 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 ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 August 8, 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 November 8, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC 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 electronic 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
pat.sheehan@state.mn.us

Telephone: (651) 201-7205
Fax: (651) 215-0541

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

5401s14epoc.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245401	A. BUILDING _____ B. WING _____	05/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL HEALTH CARE	**444 NORTH CORDOVA LE CENTER, MN 56057**

(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. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic 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 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the safe practice of self-administration of medications for 1 of 1 resident (R7) who was observed self-administering a nebulizer treatment. Findings include: On 5/7/14, at 7:12 a.m. licensed practical nurse (LPN)-D was observed to set up a nebulizer (drug delivery system used to administer medication in form of a mist inhaled into the lungs) medication treatment for R7. The LPN-D was placed a face	F 176	F176 Central Health care assures that each resident is assessed at least quarterly and as needed using the self administration assessment Form. 1) Review of the identified resident's chart was performed, assessment for self administration of medication was performed and care plan was reviewed. 05/16/14. 2)Staff involved was reeducated 05-11-2014 Will continue to educate staff as needed for self administration of medication	5/28/14

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

Electronically Signed | 05/28/2014

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	245401	A. BUILDING _____ B. WING _____	05/08/2014

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mask on R7's face and left the room, returning to the medication cart located outside of the resident room. A nursing assistant (NA)-A was in the room with the resident when LPN-D applied the face mask for R7, but then left the room at 7:16 a.m., leaving the resident alone to self-administer the nebulizer treatment. LPN-B returned to the room at 7:22 a.m., removed the face mask and rinsed the mask and chamber.

R7's current physician's order dated 3/10/14, directed staff to administer ipratropium-albuterol (for Duoneb for treatment of bronchospasm) 0.5-3 mg/3 ml (milligram/milliliter) via nebulizer twice daily. R7's orders did not include approval by the physician for self-administration of medication.

The self-administration assessment (dated 7/1/13 and reviewed 3/31/14), indicated the resident was deemed unable to safely self-administer medications, because "Resident has intermittent confusion, memory loss and hx [history] of dementia. Resident is unable to dispense own medications, staff will continue to dispense and administer medications per MD [physician] orders."

The care plan for R7 dated 7/8/13, indicated the resident an alteration in respiratory status, and staff was directed to administer respiratory medications as ordered. The care plan did not indicate R7 was able to self-administer medication. A care plan revision on 4/8/14 noted, "Resident will yell out make funny noises when taking medication d/t [due to] does not like taste."

R7's quarterly Minimum Data Set (MDS) dated 4/3/14, indicated the resident had a diagnosis of

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F 176	Continued From page 2 chronic obstructive pulmonary disease. It was noted the resident was cognitively intact, although also had a diagnosis of Alzheimer's disease. The director of nursing (DON) was informed of the observation on 5/9/14, at approximately 7:30 p.m. No further comment or information was provided. The Medication Administration General Guidelines policy revised on 3/14, indicated residents are allowed to self administer, medications when specifically authorized by the attending physician and in accordance with procedures for self administering of medications.	F 176		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		5/28/14

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F 279	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop care plan approaches for 2 of 3 residents (R47, R11) who were combative during cares. Findings include: R47's care plan dated 4/29/14 noted the resident had Alzheimer's disease, had fragile skin, bruised easily and swung out arms and legs at times during transfers. Staff was reminded to "be extra careful when completing cares." The care plan did not specify the resident's combativeness with cares and how to minimize the risk for injury to the resident. R47 was observed on 5/6/14, at 11:20 a.m. and slightly faded brownish-purplish bruising was noted on both shins, as well as a jagged angled wound across the left shin. In addition, multiple faint areas of mottled bruises were also seen on the backs of both hands. Padded cloth skin protectors covered both the resident's forearms. On 5/8/14, at 11:23 a.m. the DON explained that the resident bruised easily, which was why they initiated the use of arm protectors, but she explained that R47 was "kind of resistive" to cares, had fragile skin, and "just bruises easily." The DON said she had no knowledge of whether it was outlined in the resident's care plan. R11's care plan dated 4/10/14, identified the resident as at risk for skin tears and bruising, propelled own wheelchair short distances, was	F 279	F 0279 Central Health Care has reviewed and revised the behavior monitoring sheets to individualize specific target behaviors and approaches. Care plan reviewed and revised as needed to address resident target mood/behaviors and approaches. 05-28-2014 Educated NAR to observe daily during cares etc and report any bruising, redness or skin changes to charge nurse as needed Skin assessment performed by licensed staff weekly and as needed and documented on weekly skin assessment form.	

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F 279	Continued From page 4 assisted by two staff for cares and had frequent bruising related to cares and "swinging out at staff." Although staff were directed to observe the resident's skin daily for redness and breakdown and report to charge nurse, the plan lacked specific measures to minimize the resident's risk for skin tears and bruising, including approaches to minimize the risk for injury to the resident during cares or when self-propelling her wheelchair. R11 was observed on 5/5/14, at 7:22 p.m. to have faint bruising on the tops of her hands and a grape-sized bruise on the top of her right hand. The following day at 4:35 p.m. R11 was observed trying unsuccessfully to move her wheelchair behind a closed door in her room. Her right arm and hand bumped the door as she tried to move the chair. On 5/8/14, at 4:43 the resident was propelling her wheelchair down the hall and was bumping into the side rail. Following the observation NA-C was interviewed at 4:45 p.m. and stated R11 sometimes tried to hit staff and, "I block her by putting my hands in front of me." The DON was interviewed 5/7/14 at 7:40 a.m. and explained that R11 was vulnerable to bruising or other skin issues, and after the bruises had been reported by the surveyor, she revised R11's care plan to reflect the risk for bruising, included directions for staff to observe for bruises daily. The plan, however, did not include specific direction for staff as to how to minimize the risk for injury to R11 during cares.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		5/28/14

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F 282	Continued From page 5 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to follow the care plan for reporting and monitoring for skin alterations as directed for 1 of 3 residents (R9) reviewed for non-pressure related skin conditions. Findings include: R9's care plan dated 4/10/14, noted the resident had normal discolorations on the tops of both hands due to "normal ADL [activities of daily living] functions." Staff was to observed the resident's skin daily and report any changes to the charge nurse. R9 was observed with large purplish discolorations/bruising of the tops of both hands, with the left hand appearing swollen on 5/6/14, at 11:12 a.m. The discoloration/bruising covered the majority of the tops of both hands, and R9 was unable to describe the cause. A nursing assistant (NA)-C who routinely worked with R9, including every day except Friday during the week of 4/28/14 to 5/4/14, was interviewed on 5/6/14, at 4:25 p.m. NA-C reported she noticed new bruising on the tops of the resident's hands and one more than the other, but she was unable to recall if or when she reported it.	F 282	F 0282 Central Health Care assures that Weekly skin assessments to be performed by licensed staff on all residents and documented on Weekly skin assessment form and as changes occur in residents skin condition. 05-12-2014 Policy and procedure has been reviewed and changes made 05-09-2014 Will continue to educate staff to observe and report any changes in skin condition to licensed staff as needed and to follow the care plan. Care plans have been reviewed and revised as needed. Follow skin care policy and procedure protocol.	

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F 282	Continued From page 6 NA-D who was familiar with R9 and had worked with her the previous week on Thursday 5/1 and Friday 5/2/14, was interviewed on 5/6/14, at 4:25 p.m. NA-D's impression was that the left hand was generally more discolored than the right, but she also noticed new brushing of both hands the previous week but could not recall what day it was or if she had reported the charge to the nurse. NA-E who worked consistently with R9, including on Tuesday 4/29 and Saturday 5/3/14, was interviewed on 5/7/14, at 9:36 a.m. NA-E stated he noticed brushing on the resident's hands the previous week, "I think it was Saturday." NA-E felt it had occurred about 3-4 days prior to the observation, and did not recall if he had reported it to the nurse. The director of nursing (DON) stated on 5/7/14, at 8:00 a.m. R9's that the care plan had not been followed and staff had not reported the bruises to the charge nurse, therefore the bruises were also not monitored.	F 282		
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:	F 309		6/11/14

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F 309	Continued From page 7 Based on observation, interview and document review the facility failed to comprehensively assess for potential contributing factors related to behavioral issues prior to initiation of antipsychotic medication for 1 of 5 residents (R9) who utilized antipsychotic medication, as well as for 3 of 3 residents (R9, R24, R47) who were observed with skin alterations. Findings include: R9's physician orders dated 3/5/14, revealed a new order for the antipsychotic Abilify 5 mg for "psychosis" however, the prescribing psychiatrist failed to identify specific target behaviors warranting the use of the medication, as well as appropriate interventions and monitoring to determine effect the medication had on the resident's behavior. Interdisciplinary Progress Notes dated 3/5/14, at 10:00 a.m. indicated R9 was pacing the hallways, cursing, yelling at other residents and staff, attempted to push another resident's wheelchair, did not take her morning medications, and was described as "very hard to redirect." At 11:45 a.m. it was noted, "Writer spoke with [psychiatrist]--she ordered Abilify 5 mg po [orally] daily for psychosis. Resident has since calmed down from Ativan given at 1020 [10:20 a.m.]." The 5/14 Behavior Monitoring Form--Antidepressant Medication for Abilify identified "target behaviors" of sadness and crying (noted as not present during 5/1 to 5/7/14). Generic interventions for both Ativan and Abilify included take to bathroom, positive reinforcement, time out, redirections, food/fluids, music, and medication.	F 309	F 0309 Central Health Care initiated a weekly skin assessment to be performed by nursing weekly and as needed on all residents and to be documented on weekly skin assessment form. 05-12-2014. Care plans have been reviewed and revised as needed. Skin assessment policy and procedure was reviewed and revised. 05-09-2014 Policy and procedure for purple/discolored area (AKA bruising) was reviewed and revised. Staff educated to observe for redness, bruising, skin tears and any skin changes daily with cares and to report to charge nurse immediately as needed. Staff will continue to be educated as needed and to follow skin care guidelines per facility policy and procedure to help prevent, protect and treat skin conditions and wounds, to document and care plan preventative approaches. Central Health Care has reviewed and revised the behavior monitoring sheets to individualize specific target behaviors and approaches. Care plan reviewed and revised as needed to address resident target mood/behaviors and approaches. 05-28-2014 Social Services and nursing evaluate medical record and behavior monitoring sheets monthly and as needed. Will update MD as needed. Staff educated on 05-28-2014 on documentation of individualized target	

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F 309	Continued From page 8 Psychiatric notes revealed the resident had last been seen on 10/16/13, and the resident had tolerated a decrease in Abilify "quite well...In order to comply with gradual dose reduction on neuroleptics would like to discontinue Abilify 5 mg for now and observe the patient's behavior and progress." No further evidence of psychiatric visits were located in the resident's medical record. A physician progress notes dated 3/28/14, indicated R9's primary disability was dementia, and "Since her last visit, there has been steady deterioration and increasing behavioral issues. Subsequently [psychiatrist] has been employed to help improve her behavior so that she can maintain her present level of care and also environment. Starting to do a lot more wandering. She is having difficulty with her diurnal [daytime] cycle, now spending large periods of time awake. Ativan and Abilify have been added to help control behaviors--behavioral changes which I am attributing to stage of dementia. I am deferring behavioral management to [psychiatrist's] services." R9 was observed with large purplish discolorations/bruising of the tops of both hands, with the left had appearing swollen on 5/6/14, at 11:12 a.m. The discoloration/bruising covered the majority of the tops of both hands, and R9 was unable to describe the cause. R9's significant change Minimum Data Set (MDS) dated 4/3/14, indicated R9 had short and long term memory problems and severely impaired decision making skills, with diagnoses including anxiety and Alzheimer's disease.	F 309	behaviors, documenting and using non-pharm-logical interventions and the need for documentation to justify adding psychotropic medication and needing perimeter for prn medications. Will continue to educate as needed. Staff will continue to work with pharmacist, psychiatrist and MD to ensure cares and services to highest well being of our resident.	

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F 309	Continued From page 9 When interviewed on 5/6/14, at 4:15 p.m. the director of nursing (DON) reported she had reviewed incident/accident reports for the past month and no incident reports had been initiated for R9. After reviewing R9's medical record, the DON stated an incident on 5/1/14 was documented noting the resident was combative during cares. The DON then requested the evening shift registered nurse (RN)-A complete an incident report related to the bruising on R9's hands. The DON had assessed the resident's hands and reported that although the resident's hands were "large," she did not believe the left hand was swollen. The DON determined the bruising to the tops of R9's hands must have resulted from her combativeness during cares on 5/1/14, in addition to some "normal discoloration." An Incident/Accident Report after the interview on 5/6/14, at 5:20 p.m. revealed, "Noted discolored area on left hand (posterior) measured 9 cm [centimeters] x 8 cm. Does not present as swollen or with inflammation. No c/o [complaints] pain." The back of the form dated 5/7/14, indicated "Upon investigation noted resident on 5/1/14 resident was hitting out at staff. Res [resident] did receive Ativan IM d/t [intramuscularly due to] unsuccessful redirection. Resident is known to be resistive with staff. Res currently on hospice. Is also followed by [psychiatrist] routinely--Ativan was helpful. Will observe daily as needed for bruising, report to charge nurse and follow NH [nursing home] protocol." The Interdisciplinary Progress Notes revealed no information or monitoring related to the bruising. A nursing assistant (NA)-C who routinely worked	F 309		

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with R9, including every day except Friday during the week of 4/28/14 to 5/4/14, was interviewed on 5/6/14, at 4:25 p.m. NA-C reported she noticed new bruising on the tops of the resident's hands and one more than the other, but she was unable to recall if or when she reported it.

NA-D who was familiar with R9 and had worked with her the previous week on Thursday 5/1 and Friday 5/2/14, was interviewed on 5/16/14, at 4:25 p.m. NA-D's impression was that the left hand was generally more discolored than the right, but she also noticed new bruising of both hands the previous week but could not recall what day it was or if she had reported the charge to the nurse.

In a further interview with the DON on 5/6/14, at 4:30 p.m. indicated she interviewed a licensed practical nurse (LPN)-C and a trained medication aide (TMA)-A who both worked the evening shift on 5/5/14 and both reported they had not observed bruising on R9's hands. The following day at 8:00 a.m. the DON stated the weekly skin assessments had not been completed for R9, nor had the changes in her hands been assessed by nursing staff.

NA-E who worked consistently with R9, including on Tuesday 4/29 and Saturday 5/3/14, was interviewed on 5/7/14, at 9:36 a.m. NA-E stated he noticed bruising on the resident's hands the previous week, "I think it was Saturday." NA-E felt it had occurred about 3-4 days prior to the observation, and did not recall if he had reported it to the nurse.

R47 was observed on 5/6/14, at 11:20 a.m. and slightly faded brownish-purplish bruising was

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noted on both shins, as well as a transverse laceration (a jagged angled wound) across the left shin. In addition, multiple faint areas of mottled bruises were also seen on the backs of both hands. Padded cloth skin protectors covered both the resident's forearms.

R47 was admitted to the facility in 2014 with diagnoses including Alzheimer's disease, pedal edema (build up of excess fluid in the tissues) muscle spasms of the lower extremities and hypothyroidism (potentially contributing to bruising). The resident's care plan dated 4/29/14 noted the resident had fragile skin and bruised easily and swung out arms and legs at times during transfers. Staff was reminded to "be extra careful when completing cares." The care plan did not specify the resident's combativeness with cares and how to minimize the risk for injury to the resident, or hypothyroidism as a potential contributing factor.

During an interview on 5/6/14, at 4:02 p.m. R47's family member (F)-A reported the shin discolorations were present prior to the resident's admission to the facility. F-A stated the resident was not on medications known to contribute to bruising, but her skin had "always been easily bruised...Just a touch gets [R47] a bruise." F-A said the bruising on the shin resulted from a wheelchair that was replaced soon after the resident's admission. F-A explained that the resident placed her feet on the floor behind the metal foot pedals, and then any movement of the chair pushed the pedals into her shins.

R47's Skilled Daily Nurses Notes included check boxes for bruises and skin tear/lacerations. No check mark were noted from 3/16 to 4/20/14, and

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daily check marks were noted from from 4/21 to 4/26/14. A detailed description was lacking as to the extent, location, size, color, etc. of the bruises and lacerations. In addition, ongoing assessment and monitoring of the wounds was not documented.

A hospice registered nurse (RN)-B who was working with R47 was interviewed on 5/7/14, at 9:25 a.m. and stated, "She's got bruises--we should pull this down," and proceeded to adjust the arm protector on the resident's right arm." RN-B stated R47 was not on a blood thinner, but was probably part of the aging process and thin skin.

On 5/8/14, at 11:23 a.m. the DON explained that the resident bruised easily, which was why they initiated the use of arm protectors, but she explained that R47 was "kind of resistive" to cares, had fragile skin, and "just bruises easily." The DON said she had no knowledge of whether it was outlined in the resident's care plan.

R11 was observed on 5/5/14, at 7:22 p.m. to have faint bruising on the tops of her hands and a grape-sized bruise on the top of her right hand. The following day at 4:35 p.m. R11 was observed trying unsuccessfully to move her wheelchair behind a closed door in her room. Her right arm and hand bumped the door as she tried to move the chair. On 5/8/14, at 4:43 the resident was propelling her wheelchair down the hall and was bumping into the side rail.

Following the observation NA-C was interviewed at 4:45 p.m. and stated R11 sometimes tried to hit staff and, "I block her by putting my hands in front of me." She stated the grape-sized bruise

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was "new" and although she had not worked the previous day, she had not seen it before. At 4:38 p.m. NA-D described the bruise on R11's hands as "fresh" and said it had not been observed "yesterday."

A psychiatric note regarding R11 dated 3/28/14, noted, "She is unpredictable and wanders the hallways--has been aggressive with residents verbally and physically."

A Minimum Data Set (MDS) dated 4/10/14, revealed R11 had diagnoses including dementia and diabetes. R11 was unable to complete cognitive assessment or communicate needs effectively to staff. R11 was also prescribed the pain medication Tramadol three times daily, known to potentially contribute to bruising and bleeding.

R11's care plan dated 4/10/14, identified the resident as at risk for skin tears and bruising, as well as redness and breakdown, propelled own wheelchair short distances, was assisted by two staff for cares and had frequent bruising related to cares and "swinging out at staff." Although staff were directed to observe the resident's skin daily for redness and breakdown and report to charge nurse, the plan lacked specific measures to minimize the resident's risk for skin tears and bruising, including approaches to minimize the risk for injury to the resident during cares.

A nursing note dated 4/30/14, at 10:00 p.m. revealed R11 was attempting to hit at staff and was given Ativan. A nursing note dated 5/3/14 at 11:15 p.m. revealed R11 was yelling at staff and other residents and was again administered Ativan.

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F 309	Continued From page 14 During an interview on 5/6/14, at 3:55 p.m. the DON stated she was unaware R11 had any bruises and no incident report or documentation to that effect was available. The following day at 7:40 a.m. the DON explained that R11 was vulnerable to bruising or other skin issues and body assessments were completed weekly. She verified weekly skin audits had not been completed according to facility procedures. She further stated that she revised R11's care plan to reflect the risk for bruising, included directions for staff to observe for bruises daily. The expectation was that bruises would be reported when observed, and nurses would then monitor them. A facility policy regarding prevention, identification, assessment and treatment of skin alterations was requested, but was not received.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical	F 329		5/28/14

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F 329	Continued From page 15 record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify adequate indications and to utilize non-pharmacological interventions prior to the use of anti-anxiety and antipsychotic medication for 1 of 5 residents (R9) and failed to ensure recommended laboratory testing was conducted for 1 of 5 residents (R32) and failed to utilize non-pharmacological interventions prior to the sue of a sleep aide medication for 1 of 5 residents (R32) reviewed for unnecessary medication use. Findings include: The facility failed to identify adequate indications for as needed anti-anxiety medication and document non-pharmacological interventions attempted prior to the use of the medication. R9's significant change Minimum Data Set (MDS) dated 4/3/14, indicated R9 had short and long term memory problems, severely impaired decision making skills, and diagnoses included anxiety, depression and psychotic disorder and Alzheimer's disease. R9 was observed smiling and laughing on 5/7/14,	F 329	F329 Central Health Care works to ensure that each resident□s drug regimen is free from unnecessary drugs. 1. The one identified resident□s drug regimen, care plan and documentation has been reviewed by involved nurses the physician, and other involved professionals as needed. Revisions in psychoactive medications will be justified prior to implementation. Care plans have been updated. Education to the resident regarding risk verses benefits of the medication has been provided and documented. 2. All involved staff has been retrained on necessary assessment and documentation. The pharmacist together with the DON and each involved physician will review all residents with monitoring issues and document decisions to resolve any problems with unnecessary medications 3. The DON, together with the Pharmacist will continue to review and	

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F 329	Continued From page 16 at 9:15 a.m. while standing near the nursing station. At 9:32 a.m. an activity aide (AA)-A encouraged R9 to join the table where three other residents were seated. Although the resident initially hestitated, she joined the other residents and watched as they played cards until 9:55 a.m. At 11:13 a.m. AA-A attempted to verbally redirect R9 out of the lobby area. R9 yelled at staff and refused to leave the area. AA-A stated R9 had hit R6 in the head while the other resident was seated in a reclining chair in the lobby area. A nursing assistant (NA)-A attempted to verbally redirect R9 out of the lobby. R9 resisted by pulling on NA-A's arm with both of her hands. At 11:19 a.m. a licensed practical nurse (LPN)-D redirected the resident to sit down at a table outside of lobby area, and offered the resident coffee. The resident declined the coffee, but remained seated for approximately two minutes before she began walking around the facility. At 11:26 a.m. LPN-D was observed in medication room preparing lorazepam intramuscular injection. LPN-D informed the surveyor, "We have an order to give this IM" and said the staff "have to give it to her when she gets like this." At 1:00 p.m. R9 sat in a chair in the lobby with her eyes closed (appeared asleep) in the lobby area. The physician orders dated 3/28/14, indicated a order for lorazepam (Ativan) 0.5 mg two tabs by mouth every 30 minutes prior to bathing (1/29/14), lorazepam 1 mg by mouth 30 minutes prior to bath if needed (12/11/13), lorazepam 0.5 mg every four hours as needed for agitation (1/29/14) and Ativan 0.5 mg intramuscularly (IM) every four hours as needed for severe agitation (2/26/14). The physician orders failed to identify the symptoms of anxiety that required the use of the anti-anxiety medication. Further review of the	F 329	document recommendations and physician responses. Problems identified will be remedied and training will again be provided. . 4. The facility medication profile from the pharmacist is discussed quarterly by the members of the CQA/CQI committee. Problems with justification for medications and changes will be reported to the Medical Director for resolution. The DON, Pharmacist and Social Services Director remain responsible. 5. Mood and behavior monitoring sheets and care plan were reviewed and revised with target behaviors and individualized interventions. Mood and behavior sheets will reviewed monthly and as needed. Staff have been educated and instructed to try all interventions prior to any medications given. 05-21-2014 6. Nursing staff will work with physician, pharmacist and psychiatrist to continue to attempt dose reductions as appropriate.	

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F 329	Continued From page 17 order revealed R9 was started on hospice on 3/23/14, for diagnosis of congestive heart failure. Review of the Medication Administration Record revealed monthly documentation as follows: 1) In 2/14, lorazepam 1 mg 30 minutes prior to bath was given four times, Ativan 0.5 mg for agitation was given 10 times, and Ativan 0.5 mg IM was given once. Reasons documented for administration included swearing at visitors, yelling/arguing, hitting at nurse, trying to get outdoors, anxious and crying. 2) In 3/14, lorazepam 1 mg prior to bath if needed was given four times, lorazepam 0.5 mg for "severe" agitation was given 18 times and Ativan 0.5 IM was given once. Reasons documented for administration included going into other resident rooms, defecating in lobby, threatening other residents and hitting out at other residents. 3) In 4/14 lorazepam 1 mg prior to bath if needed was given eight times, lorazepam 0.5 mg as needed was given five times and IM was given once. Reasons documented for administration included crying, swearing, wandering and anxious. 4) For the first week of 5/14 lorazepam 1 mg prior to bath if needed was given once, and lorazepam 0.5 mg was given once and IM twice. Review of the Interdisciplinary Progress notes revealed lack of documentation related to non-pharmacological interventions attempted prior to giving anti-anxiety medication before the resident's bath. On multiple occasions it was documented that staff could not redirect R9's	F 329		

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behavior, however, it was not evident in the documentation that interventions were utilized prior to the administration of psychotropic medications. Examples were as follows:

1) On 2/15/14, "Very angry and upset trying to get out of facility bothering other residents yelling at them unable to redirect. PRN Ativan was given."
2) On 3/3/14, "Has been very angry and irritating other residents did take prn Ativan but helped for a little while did become irritated with staff and argumentative."
3) On 3/5/14, "Resident was pacing in hallways, cursing, yelling at other residents/staff. Attempted to push another resident around in w/c [wheelchair], was wandering in other people's room. Very hard to redirect, TMA [trained medication aide] informed writer that resident did not take am meds [medications]. Writer was able to give resident prn Ativan."
4) On 3/7/14, "Resident wandering through out facility. Received Ativan PRN at [10:40 a.m.] for hitting out at staff/restlessness. Effective at [1:00 p.m.] decreased agitation and cooperative."
5) On 3/10/14, "Resident was noted to be agitated with pacing and grabbing at staff and family...no physical contact made with residents. Ativan 0.5 mg PRN was given at [10:30 a.m.] presents as calm and eating at this time--noted to be smiling."
6) On 3/11/14, "Resident unable to redirect. Yelling at staff. Trying to get out the back door and front door. Ativan given which was effective."
7) On 3/16/14, "Very upset--yelling at other residents and staff. Wandering into others rooms trying to push other residents w/cs, prn Ativan given at [5:00 p.m.]and was effective."
8) On 3/22/14, "Attempted to slap out at staff and another res [residents] with no contact. Ativan

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F 329	Continued From page 19 given d/t [due to] unable to redirect at 11:30." 9) On 3/3/1/14, "Res yelling at staff unable to redirect. Going to front door and attempting to get out. Ativan PRN was given which was helpful. Res currently sitting lobby". 10) On 5/3/14, "Arguing with staff. Swearing, unable to redirect refuses cares, sitting in lobby at times and then wanders around. Ativan given at this time." 11) On 5/5/14, "Swearing, wandering, yelling at staff and other residents very angry, unable to redirect prn Ativan given at [3:15 p.m.] and is resting in bed at this time." Behavior Monitoring Form-Anti-Anxiety Medications for 5/14, indicated the following target behaviors were being monitored for R9: agitation, aggression, wandering and negative statements. The form included generic interventions such as taken to bathroom, positive reinforcement, time out, redirections, food/fluids, music, medication offered. Refusal/resistive with baths with same generic interventions was also listed, although staff consistently gave Ativan 4-8 times a month before R9's bath without documented interventions attempted prior to medication use. Review of consulting psychologist report dated 3/28/14, indicated resident has disorganized thinking, delusional thinking, poor nutrition at times, sad, tearful, yells at others and refuses to bath." Specific recommendations were provided for interventions/strategies to use with R9. Those included: Staff could reminisce about fishing with her husband to help improve her mood, she said we "lived for fishing." Could connect with her on this when she is agitated to calm her down. She used to sew so activities could show her	F 329		

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magazines with sewing in them or put it on TV for her to watch. Her wandering may help reduce some of her agitation and improve her mood provided she does not interfere with other residents."

R9's care plan dated 4/10/14, referred to generic interventions such as approach from the front, walk in step with resident before redirecting, avoid over stimulation (noise, crowding, other physically aggressive residents), If resident looked for family other staff were to reassure her others knew where to her family members, when resident began wandering comfort measures were to be provided for basic needs such as pain, and the resident was to be allowed to have control. Although not specified in the plan, staff were directed to refer to the psychologist's recommendations.

Although both the care plan and consulting psychologist identified multiple interventions, facility documentation did not reflect interventions that were attempted prior to administering anti-anxiety medication, including prior to baths.

When interviewed on 5/8/14, at 2:00 p.m. a registered nurse (RN)- A who has worked at facility for several years explained that staff may not have administered R9 Ativan prior to her weekly bath if the resident was in a good mood. RN-A stated resident did better with staff she was more familiar with than those she was not.

A nursing assistant (NA)-B who had also worked at the facility for several years was interviewed on 5/8/14, at 2:27 p.m. amd said R9's behaviors included wandering and swearing, as well as resisting toileting, going to bed and bathing.

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F 329	Continued From page 21 NA-B stated resident was hard to redirect and became defensive. Calming the resident was "hard" and R9 usually had to be given medication. When interviewed on 5/8/14, at 5:33 p.m. the director of nursing (DON) indicated different interventions had been tried with R9 including offering food, taking to bathroom, explaining cares, but acknowledged interventions were not consistently documented. The DON also acknowledged the physician orders for anti-anxiety medication were not specific to identifying symptoms of anxiety that required the use of the medication. No adequate indications for use of antipsychotic medication. R9 was also prescribed the antipsychotic Abilify 5 mg for psychosis by a psychiatrist on 3/5/14, however, the psychiatrist failed to identify target behaviors that warranted the use of the antipsychotic medication. An Interdisciplinary Progress Note dated 3/5/14, at 10:00 a.m. indicated the resident was pacing in hallways, cursing, yelling at other residents/staff. Attempted to push another resident around in w/c, was wandering in other people's room. Very hard to redirect, TMA informed writer that resident did not take am meds. Further review of progress notes indicated on 3/5/15, at [11:45 a.m.] "Writer spoke with...[psychiatrist] she ordered Abilify 5 mg po [orally] daily for psychosis. Resident has since calmed down from Ativan given at [10:20 a.m.]." The Behavior Monitoring Form--Antidepressant Medication for 5/14, for Abilify identified target	F 329		

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behaviors as sadness and crying episodes (had not occurred from 5/1 to 5/7/14). The form included the same generic interventions identified for the use of the anti-anxiety medication such as taken to bathroom, positive reinforcement, time out, redirections, food/fluids, music, and medication.

Psychiatric notes revealed the resident had last been seen on 10/16/13, and the resident had tolerated a decrease in Abilify "quite well...In order to comply with gradual dose reduction on neuroleptics would like to discontinue Abilify 5 mg for now and observe the patient's behavior and progress." No further evidence of psychiatric visits were located in the resident's medical record.

A physician progress notes dated 3/28/14, indicated R9's primary disability was dementia, and "Since her last visit, there has been steady deterioration and increasing behavioral issues. Subsequently [psychiatrist] has been employed to help improve her behavior so that she can maintain her present level of care and also environment. Starting to do a lot more wandering. She is having difficulty with her diurnal [daytime] cycle, now spending large periods of time awake. Ativan and Abilify have been added to help control behaviors--behavioral changes which I am attributing to stage of dementia. I am deferring behavioral management to [psychiatrist's] services."

The prescribing psychiatrist facility failed to identify the target behaviors that required the use of the antipsychotic medication for appropriate monitoring and interventions and to determine effectiveness of medication for continuation or

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F 329	Continued From page 23 reduction. The monthly consultant pharmacist reviews revealed no recommendations of drug irregularities over past 10 months. R32's physician orders dated 3/17/14, indicated an order for simvastin (Zocor) 40 mg at bedtime for hypercholesterolemia (started on 4/20/12). The physician orders indicated a basic metabolic panel every six months (May/November) which included tests for liver disease. Laboratory reports in R32's medical record did not include evidence the liver function testing had been completed. Liver function testing to help diagnose and monitor for liver disease or damage is recommended consistent with manufactures recommendations, and is generally accepted as prior to initiation of the therapy, at 12 weeks following both initiation of therapy and any increase in doses, and periodically (e.g. semiannually thereafter). When interviewed on 5/8/14, at 5:13 p.m. the assistant director of nursing (ADON) reviewed the medical record and could not find evidence that liver function tests were done. The ADON then called the lab and inquired when liver function tests were last completed. The laboratory staff reviewed records back to 9/2012, and were not able to find any documentation that lover function tests were completed for R32. R32 was also prescribed the antidepressant Trazodone 25 mg at bedtime PRN, which is commonly used to promote sleep. However, the medication was administered without an	F 329		

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F 329	Continued From page 24 assessment indicating the medication was warranted. The resident utilized the medication 11 times in 4/14, and once in the first week of 5/14. R32's medical record lacked a sleep hygiene assessment, as well as documentation related to the use of non-pharmacological interventions prior to the initiation of the medication. When interviewed on 5/8/14, at 4:55 p.m. the assistant director of nursing (ADON) reviewed R32's record and reported that most of the time the medication was administered at the resident's request. The ADON confirmed that non-pharmacological interventions prior to the administration of the medication were not documented. The ADON explained that staff should have documented the resident's sleep patterns for seven days after change in sleep aide medication. R32's medication had been reduced from scheduled use to PRN use on 3/17/14, however, the ADON verified it had only been completed for two days following the decrease in Trazodone for R32. When interviewed on 5/8/14, at 4:58 p.m. the DON acknowledged a sleep hygiene assessment had not been completed for R32 and stated she was currently working on developing a sleep hygiene assessment.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and	F 356		5/28/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245401	A. BUILDING _____ B. WING _____	05/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL HEALTH CARE	**444 NORTH CORDOVA LE CENTER, MN 56057**

(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 356	Continued From page 25 unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to post actual licensed staffing hours as required. This had the potential to affect all 31 residents and visitors to the facility. The staffing hours posting was not found on 5/5/14 at the time of an initial tour of the facility but was located the following day at 2:38 p.m. on the medication room door that was visible to persons passing, but not in a conspicuous place as required. In addition, the space for resident census was blank, and the hours were not filled in	F 356	F356 Central Health Care has revised the nurse staffing information to meet the requirements of the state health department. 05-07-2014 Staff involved was educated on the data requirements for nursing staff information. 05-07-2014 Central Health Care will continue to post the staffing information.	

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F 356	Continued From page 26 correctly. Work time was listed as full time equivalents (FTE) instead of actual hours worked by employees. FTEs were listed by category of employee instead the total hours of each licensed staff each shift. Licensed nurses were listed as "RN/LPN" rather than separated. A review of the previous two weeks' postings revealed additional incorrect or incomplete information. In an interview on 5/8/14, at 11:17 a.m. the director of nursing (DON) indicated that she did not know how the hours were supposed to be displayed. The DON asked for clarifications as to how the information should have appeared on the posting. On 5/8/14, at 1:33 p.m. the facility's scheduler stated she would make changes to the hours postings from then on as required.	F 356		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation	F 425		5/28/14

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F 425	Continued From page 27 on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications administered via a feeding tube were administered in accordance with standards of practice for 1 of 1 resident (R27) who received medications via through a gastric tube. Findings include: R27's physician orders dated 3/17/14, revealed no order directing staff to administer medications together through a gastric tube (G-tube inserted into the stomach for feeding and/or medications). On 5/7/14, at 8:21 a.m. licensed practical nurse (LPN)-A set up medication for R27 which included four liquid medications and eight non-liquid medications. LPN-A mixed all liquid medication together which included omeprazole (antacid), certa-vite (vitamin), and loratadine (allergies). LPN-A then crushed all other medications including amlodipine (hypertension), baclofen (muscle spasms), metoprolol (for hypertension), Aldactone (hypertension), vitamin D3, Robaxin (muscle spasms) and then opened a capsule of Cymbalta (antidepressant) and added them to the liquid medications. At 8:36 a.m. LPN-A put 30 cubic centimeters (ccs) of warm water through R27's G-tube followed by the medications, followed by 30 ccs of warm water. LPN-A explained that it was the resident's preference to	F 425	F 0425 Central Health Care has reviewed the policy and procedure for enteral tube administration of medications and revisions as needed. 05-07-2014 MD order was received to mix all medication together and place thru feeding tube on 05-08-2014. Care plan was reviewed and revised as needed 05-09-2014 Educated staff involved along with licensed staff on 05-07-2014. DON & ADON will reeducate staff as needed	

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F 425	Continued From page 28 have all the medications administered at the same time to nausea and vomiting, and the resident was aware of the risks of receiving the medications in that manner. R27's quarterly Minimum Data Set (MDS) dated 1/26/14, indicated R27 was cognitively intact, and had a gastric feeding tube (placed in stomach to provide nutrition and/or medication). On 5/8/14, at approximately 2:00 p.m. the director of nursing (DON) verified R27 had requested medication be administered together via the G-tube. The DON verified there was not a current physician order allowing this. The Enteral Tube Administration Policy, revised 9/14, indicated the decision to administer mediation via enteral tubes will be "based on a nursing assessment of the resident's condition and approval by the physician." The facility would ensure the safe and effective administration of enteral medications..."It is generally recommended that the medication be administered separately, however in the case of a resident with fluid restriction and or multiple medications, it is acceptable to give all medications together. Consult the resident physician if this applies for clarification. In the event of tube clogging or there is known incompatibilities between medication, revert to administering each medication individually with a 5-10 ml flush between each each."	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed	F 428		6/11/14

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F 428	Continued From page 29 pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify adequate indications for use of antipsychotic and antianxiety medication for 1 of 5 residents (R9) and to ensure laboratory testing was completed for 1 of 5 residents (R32) reviewed for unnecessary medications. Findings include: R9's physician orders dated 3/28/14, indicated a order for lorazepam (Ativan) 0.5 mg 2 tabs by mouth every 30 minutes prior to bathing (1/29/14), lorazepam 1 mg by mouth 30 minutes prior to bath if needed (12/11/13), lorazepam 0.5 mg every 4 hours as needed for agitation (1/29/14) and Ativan 0.5 mg intramuscular (IM) every 4 hours as needed for severe agitation (2/26/14). The prescribing physician, however, failed to identify anxiety that symptoms that would have warranted the use of antianxiety medication. In addiction, a psychiatrist ordered the antipsychotic medication Abilify 5 mg on 3/5/14, but failed to identify the target behaviors that warranted the use of antipsychotic medication. Consultant pharmacist reviews from the previous	F 428	F 0428 Omnicare Pharmacist will continue to review charts monthly and make necessary recommendations and changes as needed. The attending physician and director of nursing will be notified of any irregularities monthly and as needed. Reviewed with Omnicare Pharmacist the guidelines for F0428. Pharmacist was given a copy. 05-27-2014 Pharmacist reviewed R9 and R32 medical record and made recommendations as needed. 05-27-2014 Resident R9 perimeters were set for use of prn ativan po and IM. 05-27-2014 Resident R32 had liver function test completed 05-18-2014 at New Prague Mayo Health System Staff educated on setting perimeters for all prn medication as well as prn psychotropic meds , target behaviors and adequate documentation needed before psychotropic medications are started. 05-27-2014 and as needed.	

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F 428	Continued From page 30 10 months were reviewed and lacked notations of the lack of adequate indications for the use of the anti-anxiety and antipsychotic medications for R9. R32's physician orders dated 3/17/14, indicated a order for simvastin (Zocor) 40 mg at bedtime for hypercholesterolemia (started on 4/20/12). The physician orders indicated basic metabolic panel every six months (May/November) which included tests for liver disease. Review of the laboratory reports in the medical record revealed no evidence of liver function tests having been completed. When interviewed on 5/8/14, at 5:13 p.m. the assistant director of nursing (ADON) reviewed the medical record and could not find evidence that liver function tests had been completed. The ADON then called the laboratory staff who reviewed R32's records back to 9/12, and no documentation was found to show liver function tests had been competed for R32.	F 428	5/27/2014 To whom it may concern, I reviewed R32 (9/21/1949) chart on 4/23/2014. I did monitor his labs and serum creatinine had been tested on 3/4/2014. The standard, set by, CLINCAL PHARMACOLOGY, is to use serum creatinine to calculate creatinine clearance to monitor liver function and the effect of drugs on liver function . This is usually done every six months. Central Health was up to the standard monitoring R32 liver function. Donald D. Dame RPh Pharmacist Consultant Omnicare 5/27/2014 To whom it may concern, I reviewed R9 (6/15/1926) chart on 4/23/2014. There was a consultant note that she had started on Abilify 5 mg on 3/5/2014. It was not appropriate to do a dose reduction at this time. The general standard is not to suggest dose reduction for at least three months. I noted that the Abilify was discontinued on 5/21/2014. Donald D. Dame, RPh Pharmacist	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		5/28/14

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F 441	Continued From page 31 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper infection control techniques were utilized for 1 of 1 resident (R27) whose pressure ulcer dressing change was observed. In addition, the facility failed to ensure the facility's infection control program included tracking and trending of employee infections to determine possible correlations between staff and resident infections. This had the potential to affect all 31 residents in the facility. Findings include: R27's pressure ulcer dressing change was observed on 5/7/14, at 10:45 a.m. A licensed practical nurse (LPN)-A donned disposable gloves, cleansed the wound with a spray wound cleanser, and dried the surrounding skin. Without removing the contaminated gloves and performing hand washing, LPN-A proceeded with the dressing change. LPN-A picked up a piece of absorptive dressing, cut a piece to fit the wound size and tucked the dressing into the body crease and onto the wound. LPN-A then picked up an absorptive foam cover dressing and placed it over the first dressing. The dressing was then dated as changed on 5/7/14. LPN-A then removed her gloves and washed her hands. Following the dressing change at 10:57 a.m. LPN-A was interviewed regarding infection control, and verified she had not changed her gloves and washed her hands after touching the potentially contaminated supply cart, nor between the soiled and clean steps of the dressing change.	F 441	F441 Central Health Care has implemented an Employee Tracking Infection Control log & policy and procedure on 05-06-2014. Staff have been educated on policy and procedure for Employee infection control 05-08-2014. 1) Central Health Care Provides annual in-service on infection control and as needed. Infection control policy and procedure has been reviewed and revised as needed. a) Staff involved was reeducated on 05-12-2014 on proper infection control and procedure with clean and sterile dressing changes. Licensed staff was also educated on proper procedure for dressing changes on 05-25-2014	

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F 441	Continued From page 33 R27's care plan dated 8/2/13 revealed multiple diagnoses including a history of pressure ulcers and osteomyelitis (bone infection usually caused by germs through the bloodstream). The resident had a current stage II pressure ulcer on her right hip. Staff was to provide skin care in a manner consistent with the facility's protocols. The facility's undated Care Infection Control Policies and Procedures directed staff as follows: "Employees must wash their hands with soap and water after touching blood, body fluids, secretions and excretions; after removing their gloves, between contact with different patients, when hands are visibly soiled and as necessary to prevent the spread of microorganisms...Medical personnel may have to wash their hands between tasks performed for the same patient...The CDC guidelines state that employees must remove gloves and perform hand hygiene immediately after patient contact as well as after contact with a patient's environment or medical equipment...." The facility's infection control program was reviewed. The surveillance log lacked evidence of any type of monitoring of employee illnesses to determine whether resident infections were related to each other in any way. An interview conducted with the director of nursing (DON) on 5/6/14, at 1:38 p.m. revealed the facility did not track employee illnesses. The DON stated she was unaware of a facility policy regarding this practice and she was not instructed to track employee illnesses. The DON further explained employee call-in slips were kept for one year. She verified these slips were not used to track and trend employee illness for potential	F 441		

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F 441	Continued From page 34 cross-contamination with residents in the facility. She verified no log of employee illnesses or other system of tracking and trending employee illnesses was in place. The director of nursing was again interviewed on 5/8/14, at 2:33 p.m. and stated she had spoken to the facility's medical director, who agreed the practice should have been implemented. The DON stated, "I need better policies and procedures." The facility's undated Infection Control policy was reviewed and lacked direction for tracking employee illnesses.	F 441		

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	245401	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/06/2014**

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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 on May 06, 2014. At the time of this survey, Central Health Care was found 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	EPOC	

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

Electronically Signed | 05/28/2014

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.

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K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Central Health Care is a 1-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1966 and was determined to be of Type II(111) construction. In 1969, an addition was constructed and was determined to be of Type II(111) construction. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 54 beds and had a	K 000		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 census of 32 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain an automatic fire sprinkler system in accordance with NFPA 101 (2000) Chapter 19, Section 19.3.5 and NFPA 13 (1999) Chapter 5, Section 5-5.5.2.1. In a fire emergency, this deficient practice could adversely affect 10 of the 32 residents. FINDINGS INCLUDE: On facility tour between 9:30 AM and 12:30 PM on 5/06/142014, observation revealed that the laundry room and 200 wing corridor had sprinkler heads with an accumulation of dust and debris	K 056	K 056 Central Health Care Maintenance Department will inspect sprinkler heads monthly and as needed and clean as needed. Maintenance reviewed and revised as need the monthly log for Fire extinguishers and safety checks. 05-08-2014 Maintenance department cleaned all sprinkler heads on 05-06-2014	5/28/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245401	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/06/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL HEALTH CARE	**444 NORTH CORDOVA** **LE CENTER, MN 56057**

(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 056	Continued From page 3 not in accordance with NFPA 13 (99) edition. These findings were confirmed with the Maintenance Supervisor.	K 056		