DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	EDICARE/MEDICAID CERTIFICATI RT I - TO BE COMPLETED BY THE		ID: MUKC Facility ID: 00049
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245491 2.STATE VENDOR OR MEDICAID NO. (L2) 857637200	 3. NAME AND ADDRESS OF FACILITY (L3) AUGUSTANA MERCY CARE ((L4) 710 SOUTH KENWOOD AVEN (L5) MOOSE LAKE, MN 		4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 09/01/2010	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 J	<u>02</u> (L7) ESRD 13 PTIP 22 CLIA	8. Full Survey After Complaint
	34) 02 SNF/NF/Dual 06 PRTF 10 ! 0) 03 SNF/NF/Distinct 07 X-Ray 11 l	NF 14 CORF CF/IID 15 ASC RHC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
72	7) B. Not in Compliance with Program Requirements and/or Applied Waivers: SNF ICF .39) (L42)	And/Or Approved Waivers Of Th2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SNF5. Life Safety Code * Code: A* 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	6. Scope of Services Limit 7. Medical Director
17. SURVEYOR SIGNATURE	Date :	18. STATE SURVEY AGENCY A	APPROVAL Date:
		Michaelvn Bruer, Enford	cement Specialist 06/15/2018
PART II - 1	O BE COMPLETED BY HCFA REGI	DNAL OFFICE OR SINGLE ST.	(L20) ATE AGENCY
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible	20. COMPLIANCE WITH CIVII RIGHTS ACT: 		l Interest Disclosure Stmt (HCFA-1513)
	REEMENT 24. LTC AGREEMENT INING DATE ENDING DATE (L25)	26. TERMINATION ACTION: <u>VOLUNTARY</u> 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination	05-Fail to Meet Health/Safety ent 06-Fail to Meet Agreement
A. Sus	RNATIVE SANCTIONS pension of Admissions: (L44) ind Suspension Date: (L45)	04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO.	30. REMARKS	
(L28)	03001 (I	31)	
31. RO RECEIPT OF CMS-1539	32. DETERMINATION OF APPROVAL DATE		
(L32)	(I	33) DETERMINATION APPR	OVAL



Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245491

June 15, 2018

Ms. Tara Peterson, Administrator Augustana Mercy Care Center 710 South Kenwood Avenue Moose Lake, MN 55767

Dear Ms. Peterson:

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 May 4, 2018 the above facility is certified for:

72 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 72 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Montylan

Michaelyn Bruer, Enforcement Specialist Minnesota Department of Health Health Regulation Division Program Assurance Unit phone 651-201-4117 fax 651-215-9697 email: <u>michaelyn.bruer@state.mn.us</u>

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 15, 2018

Ms. Tara Peterson, Administrator Augustana Mercy Care Center 710 South Kenwood Avenue Moose Lake, MN 55767

RE: Project Numbers S5491027, H5491019, H5491020

Dear Ms. Peterson:

On April 6, 2018, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective April 11, 2018. (42 CFR 488.422)

In addition, on April 6, 2018, the Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

• Discretionary Denial of Payment for new Medicare and Medicaid admissions effective June 4, 2018. (42 CFR 488.417 (a))

This was based on the deficiencies cited by the Minnesota Department of Health, Office of Health Facility Complaints for an abbreviated standard survey completed on March 16, 2018. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On April 17, 2018, we informed you that the following Category 1 enforcement remedy would remain in effect:

• State Monitoring effective April 11, 2018. (42 CFR 488.422)

In addition, on April 17, 2018, we informed you that the following enforcement remedy would remain in effect:

• Discretionary Denial of Payment for new Medicare and Medicaid admissions effective June 4, 2018. (42 CFR 488.417 (a))

This was based on the deficiencies cited by the Minnesota Departments of Health and Public Safety for a standard survey was completed at your facility on March 29, 2018 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 were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F).

On May 10, 2018, the Minnesota Department of Health, Office of Health Facility Complaints completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal

Augustana Mercy Care Center June 15, 2018 Page 2

certification deficiencies issued pursuant to abbreviated standard survey completed on March 16, 2018. On May 21, 2018, the Minnesota Department of Health completed a PCR by review of your plan of correction and on May 18, 2018 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 March 29, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 4, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to the abbreviated standard survey, completed on March 16, 2018, and pursuant to our standard survey, completed on March 29, 2018. Respective May 4, 2018. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective May 4, 2018.

In addition, this Department recommended to the CMS Region V Office the following action:

• Discretionary Denial of Payment for new Medicare and Medicaid admissions effective June 4, 2018, be rescinded effective May 4, 2018. (42 CFR 488.417 (a))

In our letter of April 6, 2018, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 4, 2018, due to denial of payment for new admissions. Since your facility attained substantial compliance on May 4, 2018, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

Montylan

Michaelyn Bruer, Enforcement Specialist Minnesota Department of Health Health Regulation Division Program Assurance Unit phone 651-201-4117 fax 651-215-9697 email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 15, 2018

Ms. Tara Peterson, Administrator Augustana Mercy Care Center 710 South Kenwood Avenue Moose Lake, MN 55767

Re: Reinspection Results - Complaint Numbers H5491019 and H5491020

Dear Ms. Peterson:

On May 10, 2018 an investigator from the Minnesota Department of Health, Office of Health Facility Complaints, completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on March 16, 2018. At this time these correction orders were found corrected.

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

Please feel free to call me with any questions.

Sincerely,

Matury

Michaelyn Bruer, Enforcement Specialist Minnesota Department of Health Health Regulation Division Program Assurance Unit phone 651-201-4117 fax 651-215-9697 email: <u>michaelyn.bruer@state.mn.us</u>

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	-				ND TRANSMITTAL YE SURVEY AGENCY	ID: MUKC Facility ID: 00049
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245491 2.STATE VENDOR OR MEDICAID NO. (L2) 857637200		 NAME AND AD (L3) AUGUSTAN (L4) 710 SOUTH (L5) MOOSE LA 	A MERCY CAI KENWOOD AV	RE CENTI	ER (L6) 55767	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
 5. EFFECTIVE DATE CHANGE OF OWNERSH (L9) 09/01/2010 	HP	7. PROVIDER/SU	PPLIER CATEGOR	CY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
 6. DATE OF SURVEY 03/29/2018 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other 	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
13.Total Certified Beds 72 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 72 72 72 (L37) (L38) 123	2 (L18) 2 (L17) 19 SNF (L39)	Compliance 1. 4 X B. Not in Cor Requirements a ICF (L42)	nce With lequirements te Based On: Acceptable POC apliance with Progr and/or Applied Wait IID (L43)	am vers:	And/Or Approved Waivers Of TI 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNI 5. Life Safety Code * Code: B * 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	6. Scope of Services Limit 7. Medical Director
16. STATE SURVEY AGENCY REMARKS (IF	APPLICABL	E SHOW LTC CANCE	ELLATION DATE)	:		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Elizabeth Silkey, HFE NE			05/01/2018	(L19)	Douglas S. Larson, Enf	(L20)
PART I	I - TO BE	COMPLETED	BY HCFA RE	GIONAL	OFFICE OR SINGLE ST	ATE AGENCY
19. DETERMINATION OF ELIGIBILITY			IPLIANCE WITH C			
 Facility is Eligible to Participate Facility is not Eligible 	e (L21)	RI	GHTS ACT:	CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e :
2. Facility is not Eligible	(L21)		GHTS ACT:		 Ownership/Control Both of the Above 	ol Interest Disclosure Stmt (HCFA-1513)
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2. Facility is not Eligible 22. ORIGINAL DATE 23. L [*] OF PARTICIPATION E 07/01/1987 (L24) (25. LTC EXTENSION DATE: 27. A A	(L21) TC AGREEM BEGINNING L41) ALTERNATIV Suspension	ENT 2-	GHTS ACT: 4. LTC AGREEMI ENDING DATH (L25) (L44)	ENT	2. Ownership/Control 3. Both of the Above 26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure	(L30) (L30) <u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety ent 06-Fail to Meet Agreement
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered April 17, 2018

Ms. Tara Peterson, Administrator Augustana Mercy Care Center 710 South Kenwood Avenue Moose Lake, MN 55767

RE: Project Numbers S5491027, H5491019, H5491020

Dear Ms. Peterson:

On April 6, 2018, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective April 11, 2018. (42 CFR 488.422)

In addition, on April 6, 2018, the Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

• Discretionary Denial of Payment for new Medicare and Medicaid admissions effective June 4, 2018. (42 CFR 488.417 (a))

This was based on the deficiencies cited by the Minnesota Department of Health, Office of Health Facility Complaints for an abbreviated standard survey completed on March 16, 2018. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On March 29, 2018, 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 were found 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 electronically delivered CMS-2567, whereby corrections are required.

As a result of the survey findings that your facility is not in substantial compliance, the following Category 1 enforcement remedy will remain in effect:

• State Monitoring effective April 11, 2018. (42 CFR 488.422)

In addition, as a result of the survey findings that your facility is not in substantial compliance, the following enforcement remedy will remain in effect:

• Discretionary Denial of Payment for new Medicare and Medicaid admissions effective June 4, 2018. (42 CFR 488.417 (a))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective June 4, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 4, 2018.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Augustana Mercy Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective June 4, 2018. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

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:

Teresa Ament, Unit Supervisor Duluth Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health Duluth Technology Village 11 East Superior Street, Suite 290 Duluth, Minnesota 55802-2007 Email: teresa.ament@state.mn.us Phone: (218) 302-6151 Fax: (218) 723-2359

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 16, 2018 (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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver

along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services Departmental Appeals Board, MS 6132 Director, Civil Remedies Division 330 Independence Avenue, S.W. Cohen Building – Room G-644 Washington, D.C. 20201 (202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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 electronically 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. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Monty In

Michaelyn Bruer, Enforcement Specialist Minnesota Department of Health Health Regulation Division Program Assurance Unit phone 651-201-4117 fax 651-215-9697 email: <u>michaelyn.bruer@state.mn.us</u>

cc: Licensing and Certification File

		AND HUMAN SERVICES			FORM	APPROVED
		& MEDICAID SERVICES				. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY MPLETED
		245491	B. WING _		03/	/29/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA MERCY CARE C	ENTER		710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	00		
	Emergency Prepare	iance with CMS Appendix Z edness Requirements, was through 3/29/18, during a ey.				
	The facility was fou Appendix Z.	nd to be in compliance with				
F 000	INITIAL COMMENT	ſS	F 00	00		
	standard survey wa the Minnesota Dep if your facility was in requirements of 42	B, through March 29, 2018, a as completed at your facility by artment of Health to determine n compliance with CFR Part 483, Subpart B, and ong Term Care Facilities.				
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.				
5.504	on-site revisit of you validate that substa regulations has bee your verification	acceptable electronic POC, an ur facility may be conducted to intial compliance with the en attained in accordance with	- - -			5////0
F 561 SS=E		1)-(3)(8)	F 56	51 		5/4/18
	promote and facilita through support of not limited to the rig	e right to and the facility must ate resident self-determination resident choice, including but ghts specified in paragraphs (f)				
		DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE
 Hectron 	ically Signed					04/25/2018

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

PRINTED: 05/17/2018

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPI	LE CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		COMF	PLETED
		245491	B. WING			03/2	29/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA MERCY CARE C	ENTER					
				Γ	MOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 561	Continued From pa	ae 1	F 5	61			
	(1) through (11) of t	-	. 0	• •			
		esident has a right to choose s (including sleeping and					
	waking times), heal	Ith care and providers of health					
		stent with his or her interests, plan of care and other					
	applicable provision						
	§483.10(f)(2) The re	esident has a right to make					
	choices about aspe	ects of his or her life in the					
	facility that are sign	ificant to the resident.					
	§483.10(f)(3) The re	esident has a right to interact					
		e community and participate in s both inside and outside the					
	facility.						
	§483.10(f)(8) The re	esident has a right to					
	participate in other	activities, including social,					
		nunity activities that do not ghts of other residents in the					
	facility.						
		NT is not met as evidenced					
	by: Based on interview	/ and document review, the			It is the policy of Augustana Care N	loose	
	facility failed to ensu	ure resident choices and			Lake Health and Rehabilitation to e		
		onored for 4 of 5 residents d R56) who expressed desire			that residents have the right to self-determination. Augustana Car	e	
	to have two baths w	veekly. In addition, the facility			Moose Lake Health and Rehabilitat		
		nsively assess and afford			strives to allow resident choice and	na	
		schedule(s) for 1 of 5 iewed for choices and who			inclusion in decisions made regardi activities, schedules, interests and		
		bathing during the week.			plan of care. As noted during the a	nnual	
	Findings include:				survey the facility Quality Assurance Performance Improvement Commit	ttee	
	-				had been working on resident bathi	ng	
		num Data Set (MDS) dated she was cognitively intact, did			preferences as part of a facility wide quality improvement project. Resid		

Facility ID: 00049

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PRINTED: 05/17/2018

TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		245491	B. WING			00/0040
	PROVIDER OR SUPPLIER	240401	<u> </u>	STREET ADDRESS, CITY, STATE, 2		29/2018
	ANA MERCY CARE O	CENTER		710 SOUTH KENWOOD AVENU MOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 561	not reject cares, an with bathing. R12's care plan dat to provide assistance and assistance/sup undated nursing as she was to receive an extra shower on When interviewed of stated the staff, "W concern that not all to this. When interve R12 stated she has have a bath twice a happens. R12's January 2018 indicated one out of had been missed, a any report for the S R12's February 207 indicated three out provided on Wedne were provided on S R12's March 2018, indicated two out of had received a batt untitled sheet of pa received one out of R13's annual MDS was cognitively inta was totally depende care plan dated 11/	ted 1/1/18, indicated staff were ce in and out of shower room pervision for shower. R12's sistant worksheet indicated a shower on Wednesdays and a Saturdays. on 3/27/18, at 9:55 a.m. R12 ork short." R12 expressed cares are being provided due viewed on 3/2/18, at 10:10 a.m. s told the staff she would like to a week, but this rarely 8, Point of Care History report f the five Wednesday baths and the facility did not provide saturday baths. 18, Point of Care History report of the four weekly baths were esdays, and three out of four	F 56	R12, R13, R15 and R56 regarding their bathing p relation to frequency an bathing schedule prefer all residents in the facilit interviewed regarding th preferences and placed schedule that honors th bathing frequency. The procedure for bathing w updated. The policy ent preferences was review All residents will be inter their preferences includ admission, quarterly and change. All nursing star re-educated regarding r resident bathing prefere Baths completed will be week day at stand up m resident who misses a b reason will have the bat the next day. The DON audit three resident reco preferences per week x monthly x3 months. Re reviewed by the facility 0 Corrected by: 5/4/18.	oreferences in d confirmed ences. In addition by were leir bathing into a new eir choices for facility policy and as reviewed and titled resident ed and updated. rviewed regarding ing bathing upon d with significant ff will be need to ensure nces are met. reviewed every eeting. Any bath regardless of h rescheduled to or designee will ords for bathing 4 weeks then sults will be	

Facility ID: 00049

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		AND HUMAN SERVICES				FORM	05/17/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```			(X3) DATI	E SURVEY PLETED
		245491	B. WING			03/	29/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
AUGUST	ANA MERCY CARE C	ENTER			10 SOUTH KENWOOD AVENUE IOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 561	• • • • • • • • • • • • • • • • • • • •	-	F	561			
	be assisted with a back second bath on Sat	orksheet indicated R13 should bath on Wednesdays and a turdays. R13's Care ary dated 1/11/18, indicated a baths per week.					
	stated he was supp week, but there was R13 stated even if t they get pulled from to do other things. F a bath last week, th	on 3/26/18, at 1:10 p.m. R13 posed to get a bath twice a s not enough staff working. there was a bath aide working, n giving baths much of the time R13 stated he knew he missed his happened quite often, but of when he had or had not uled bath.					
	2018, showed he ha	e History report for January ad received all scheduled ays, but no documentation of re provided.					
	2018, showed R13	e History report for February had missed one out of four day baths, and no Saturday ented.					
	2018, showed he ha	e History report for March ad received two out of four and no full baths on o "partial bed bath"					
	moderate cognitive cares, and was tota bathing. R15's care two baths per week care sheet indicated	S dated 1/2/18, indicated impairment, did not reject ally dependent upon staff for plan directed staff to provide c. An undated nursing assistant d R15 was to be bathed every iven an extra bath on					

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		AND HUMAN SERVICES				FORM	05/17/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /			(X3) DAT	E SURVEY IPLETED
		245491	B. WING			03/	29/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
AUGUST	ANA MERCY CARE C	ENTER			10 SOUTH KENWOOD AVENUE NOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 561	Continued From pa Saturdays.	ge 4	F	561			
		on 3/27/18, at 2:19 a.m. R15 erns over not having enough					
	2018, indicated he	e History report for January had received three of the five and none of the Saturday					
	2018, indicated he Wednesday baths a	e History report for February had received three of the four and none of the Saturday on indicated R15 refused					
	2018, indicated he and one Saturday b untitled copy with h	e History report for March had received one Wednesday bath month. An undated, andwriting indicated R15 had ath on on 3/3/18, 3/7/18 and					
	was cognitively inta required physical he care plan dated 5/1 with bathing twice a Mondays. An undat worksheet directed Wednesdays, with R56's Care Conference	S dated 3/5/18, indicated she act, did not refuse cares, and elp in part of bathing. R56's 3/15, directed staff to assist a week on Fridays and ted nursing assistant staff to assist with bathing on an extra bath on Saturdays. ence Summary dated 3/8/18, nce for two baths per week.					
	stated they are "sho bath days will come	on 3/26/18, at 11:22 a.m. R56 ort of help for aides, some and go without a bath." R56 get "made up" if missed, and					

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		AND HUMAN SERVICES			FORM	05/17/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· í	PLE CONSTRUCTION G	(X3) DATE	E SURVEY PLETED
		245491	B. WING		03/2	29/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	TANA MERCY CARE C	ENTER		710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 561	Continued From pa this was distressing	-	F 56	1		
	2018, indicated she	e History report for January had received five of five and two of four Saturday				
	2018, indicated she	e History report for February had received three of four and two of four Saturday				
	2018, indicated she Wednesday baths,	e History report for March had received two of four and no Saturday baths. An rm indicated she had received 3/15/18.				
	nursing assistant (N short staffed and th work on the floor do baths do not get do	on 3/27/18, at 3:47 p.m. NA)-B stated they are often be bath aide gets pulled to bing nurse aide duties, and the one. NA-B continued to state nts are not able to do the missed.				
	stated bath aide get	on 3/27/18, at 3:54 p.m. NA-C ts pulled, "a lot," and they will is done the next day, but it ippen.				
	stated they do not h afternoon shift, and	on 3/27/18, on 3:59 p.m. NA-A have a bath aide on the they are unable to get baths get done on the day shift.				
		on 3/27/19, at 4:02 p.m. NA-D always get done, and they catch up on them.				

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	05/17/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` <i>´</i>		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245491	B. WING_			03/:	29/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	TANA MERCY CARE C	ENTER			10 SOUTH KENWOOD AVENUE OOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 561	Continued From pa	ıge 6	F 56	61			
	stated they can usu	on 3/28/18, at 7:05 a.m. NA-G ually get the work done but it is is do not always get done.					
		on 3/28/18, at 7:57 a.m. NA-H e had called in for the day, and t done that day.					
	stated she had offe	on 3/28/18, at 9:22 a.m. NA-I ered to do baths today for her lunteers, "They will get done					
	stated she is often t gets pulled very free	on 3/29/18, at 7:39 a.m. NA-F the assigned bath aide but equently. She can't get baths resident's other needs.					
	licensed practical n	on 3/29/18, at 10:40 a.m. nurse (LPN)-A stated she is e nurse aides with bathing as self.					
	stated they pull the there is no way to c	on 3/29/18, at 7:56 a.m. NA-K bath aide at least weekly, and catch up on the baths. NA-K she is asked to stay late to ery often.					
	registered nurse (R nursing assistant ca aide from doing bat happens, the nursir do all the baths. Th the baths have not Occasionally, a nur	on 3/29/18, at 8:01 a.m. RN)-A stated if they have a all in, they will pull the bath ths to replace them. If this ng assistants working should ney do not always report when been completed. rsing assistant will report a completed, and she reports					

		AND HUMAN SERVICES				FORM	05/17/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245491	B. WING	i		03/:	29/2018
NAME OF F	PROVIDER OR SUPPLIER		-	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
AUGUST	ANA MERCY CARE C	ENTER			10 SOUTH KENWOOD AVENUE IOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 561	this to the afternoor do it. This is not foll resident actually red shift. When interviewed of administrator stated baths not always ge addressing the issu and assurance (QA nursing (DON) state they try to get an ex have a bath aide, of stay late and try to ge A facilty policy entitl Care dated 7/15, di bath/shower will be each resident, to m resident. R62's 14-day MDS had moderate cogn extensive assistance assistance with batt During interview on explained she enjoy she could have mon however, "Everybood she would like to ha nobody had ever as her bathing preferen nursing home. R62's Point of Care 3/28/18, identified F	 an shift so that they can try and lowed up on to see if the ceived a bath on the evening bn 3/28/18, at 9:48 a.m. the d the facility was aware of etting done, they are currently us in their quality assessment vA) committee. The director of ed they are still working on it, ktra person in if they do not r will try and get someone to get the baths done. led Apollo Tub, Basic Nursing rected the frequency of weekly or as requested by eet the hygiene needs of each dated 3/14/18, identified R62 hitive impairment, required by each the fact a bath and wished re than one per week, but sked or questioned her about nces since she came to the e History report printed R62's completed bath(s) for 2 had a bath completed only 	F	561			
		Further, R62's Resident					

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		AND HUMAN SERVICES				FORM	05/17/2018 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245491	B. WING			03/2	29/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA MERCY CARE C	ENTER			10 SOUTH KENWOOD AVENUE IOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI> TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 561 F 677 SS=E	ask her preference when completing or any assessment or preference for bath was left blank. R62's medical reco evidence R62 had b input on her bathing to the nursing home On 3/28/18, at 12:2 (RN)-A was intervie for bathing schedul resident admits to t added to the bathin week" and should b preferences for add preferences for bath recorded on it addir times she desired at A facility Resident F 8/2013, directed all " are provided wi preferences." A pro directed, "On admis asked questions ref schedules." These incorporated into th ADL Care Provided CFR(s): 483.24(a)(2	igned 2/28/18, directed staff to between a bath or shower he for R62, however, lacked input on R62's choice or ing. A section labeled, "Other," rd was reviewed and lacked been assessed or afforded g schedule(s) since admitting e. 1 p.m. registered nurse wed about the facility process es. RN-A stated when a he nursing home, they are g schedule for "at least once a be asked about their litional bathing using a Resident Preference Sheet). 2's completed sheet and stated hing usually would be ng it should say how many a bath during the week. Preferences policy dated residents of the nursing home th choices regarding their cedure was listed which ssion[,] all residents will be garding their preferences for mes, bathing and activities preferences were then to be eir plan of care. for Dependent Residents	F 5				5/4/18
	§483.24(a)(2) A res	ident who is unable to carry					

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		& MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION	OMB NO.	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		G		PLETED
		245491	B. WING		03/	29/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA MERCY CARE O	CENTER		710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 677	Continued From pa	age 9	F 67	7		
	out activities of dail services to maintain personal and oral h	y living receives the necessary n good nutrition, grooming, and				
	Based on observa- review, the facility f bathing/showering residents (R3, R5, and personal groon (R214) reviewed fo	tion, interview, and document ailed to provide routine assistance for 7 of 11 R13, R15, R38, R56 and R60) ning for 1 of 11 residents r activities of daily living, and nt on staff for assistance.		It is the policy of Augustana Ca Lake Health and Rehabilitation that residents who are unable activities of daily living receive necessary services to ensure g nutrition, grooming, personal a hygiene. As noted during the a	to ensure to carry out the good nd oral	
	Findings include:			survey the facility Quality Assur Performance Improvement Co	mmittee	
	12/18/17, indicated not refuse cares, at two staff to bathe. F directed staff to pro showers. An undate	nimum Data Set (MDS) dated R3 was cognitively intact, did nd was totally dependent upon R3's care plan dated 12/12/17, ovide physical assistance with ed nursing assistant worksheet sist R3 with a shower weekly		preferences as part of a facility quality improvement project. F has been discharged from the Resident R5 is noted to freque bathing her care plan was upda include approaches for staff to resident refuses bathing in ado was interviewed regarding her preferences along with resident	king on resident bathing is part of a facility wide vement project. Resident R3 charged from the facility. s noted to frequently refuse are plan was updated to aches for staff to use when es bathing in addition she ed regarding her bathing	
	stated, "They are a	on 3/26/18, at 3:05 p.m. R3 lways short of staff," and not even get a weekly shower g to her.		R15, R38 and R56 and new be schedules were developed. Re is noted to have a diagnosis of and is not interview able; her fa interviewed regarding her past	athing sident R60 aphasia amily was	
	2018, indicated sta with a shower on 1, 1/26/18. However, signed off as given	History report for January ff should have assisted R3 /5/18, 1/12/18, 1/19/18, and the 1/12/18, bath was not , and the 1/19/18, bath was one." Therefore, R3 went for a but a shower.		In addition all residents in the f interviewed regarding their bat preferences and placed into a schedule that honors their choi regarding the frequency of bath facility policy and procedure for was reviewed and updated. Th	acility were hing new ces ns. The r bathing ne policy	
		History report for February had received a weekly shower		titled resident preferences was and updated. All residents will interviewed regarding their pre	be	

Facility ID: 00049

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		AND HUMAN SERVICES				FORM	05/17/2018 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION		E SURVEY PLETED
		245491	B. WING			03/2	29/2018
NAME OF F	PROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
AUGUST	ANA MERCY CARE C	ENTER			10 SOUTH KENWOOD AVENUE IOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677	Continued From pa	qe 10	F	677			
	in February 2018.	History report for March 2018,			including bathing upon admission, quarterly, and with significant chang nursing staff will be re-educated reg		
	indicated staff shou shower on 3/2/18, 3	Id have assisted R3 with a 3/9/18, 3/16/18, and 3/23/18. er was not signed off as being			need to ensure resident bathing preferences are met and baths are completed as scheduled. Baths completed will be reviewed each we day at stand up meeting. Any resid	eek	
	was cognitively inta required total staff a care plan dated 10/ total assist of 2 for	dated 12/19/17, indicated R5 act, did not reject cares and assistance with bathing. R5's 21/16, indicated she required bathing. An undated nursing t directed a tub bath every			who misses a bath regardless of re will have a bath rescheduled to the day. The facility policy and procedu bathing was reviewed and updated policy includes shaving of both mal female residents and was provided survey team during the survey proc	ason next ure for this e and to the	
	stated she typically fussy about who giv often not enough st weekly bath. R5 sta abdominal folds and	on 3/26/18, at 11:58 a.m. R5 does not like to bathe, and is yes her a bath, but that there is aff available to give her a ated she has a rash in her d under her breasts, and that pt clean or the rash, "Gets			The policy entitled resident preferent was reviewed and updated to inclue resident grooming/shaving preferent The facility policy on Shaving was reviewed and remains current. All residents will be interviewed regard their preferences including bathing grooming upon admission, quarter with significant change. Resident F	de nces. ling and y and R214	
	2018, indicated R3 on 1/1/18, 1/8/18, 1 However, the repor received one bath t The other dates we marked as, "Not Do	History report for January should have received a bath /15/18, 1/22/18, and 1/29/18. t indicated R5 had only he entire month on 1/15/18. re either not answered, or one-Resident Refused."			was interviewed regarding her shaw preferences and declined shaving, has been discharged from the facili nursing staff will be re-educated reg need to ensure resident bathing preferences are met and all resider require assistance with bathing are provided a bath per their preference addition residents who wish to be s	R214 ty. All garding nts who e. In haved	
	2018, indicated R5 with a bath on 2/5/1 2/26/18. Two of tho	History report for February should have been assisted 18, 2/12/18, 2/19/18, and se dates were marked as not ted at all. R5 had only received ry on 2/19/18.			will have this completed as necessa Any resident who misses a bath regardless of reason will have the k rescheduled to the next week day. DON or designee will audit three re records per week x4 weeks then m	oath The sident	

Facility ID: 00049

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DAT	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		IPLETED
		245491	B. WING _			29/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
AUGUST	ANA MERCY CARE	CENTER		710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 677	Continued From pa	age 11	F 67	77		
	indicated R5 shoul bath on 3/5/18, 3/1 Two of those dates one was not answe bath on 3/5/18. R13's annual MDS was cognitively inta was totally depend care plan dated 11 extensive assistant nursing assistant v be assisted with a second bath on Sa When interviewed stated he is suppor but there is not end stated even if there pulled from giving other things. R13 s bath last week, this	on 3/26/18, at 1:10 p.m. R13 sed to get a bath twice a week, ough staff on to do this. R13 e is a bath aide on, they get baths much of the time to do stated he knew he missed a s happens quite often, but had hen he had, or had not		x3 months to ensure bathir are completed per care pla the DON or designee will a residents per week weekly monthly x 3 months to ensu completed per the care pla be reviewed by the facility (committee. Corrected by 5	n. In addition udit three x4 weeks then ure shaving is n. Results will QAPI	
	2018, indicated he baths on Wednesc Saturday baths wa R13's Point of Car 2018, indicated R1	e History report for February 3 had missed one out of four sday baths, and no Saturday				

		AND HUMAN SERVICES					FORM	05/17/2018 APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	0	(X3) DATE	0938-0391 E SURVEY PLETED
		245491	B. WING				03/2	29/2018
NAME OF F	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, Z	ZIP CODE		
AUGUST	ANA MERCY CARE C	ENTER			SOUTH KENWOOD AVENU OSE LAKE, MN 55767	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD THE APPROPF	BE	(X5) COMPLETION DATE
F 677	• • • • • • • • • • • • • • • • • • • •	ige 12 and no full baths on	F 67	7				
	Saturdays, with two documented.							
	had moderate cogn cares, and was tota bathing. R15's care two baths per week assistant care shee	S dated 1/2/18, indicated R15 hitive impairment, did not reject ally dependent upon staff for e plan directed staff to provide c. An undated nursing et indicated R15 was to be hesday, and an extra bath on						
		on 3/27/18, at 2:19 a.m. R15 erns over not having enough						
	2018, indicated he	e History report for January had received only three of the ths,and none of the Saturday						
	2018, indicated he	e History report for February had only received three of the aths and none of the Saturday e had refused once.						
	2018, indicated he Wednesday and on An undated, untitled	e History report for March had received only one he Saturday bath this month. d copy with handwriting received another bath on on 3/9/18.						
	indicated R38 had s did not refuse cares assistance from sta	hange MDS dated 2/4/18, severe cognitive impairment, s, and required total aff for bathing. R38's care plan cted staff to assist with						

Facility ID: 00049

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	D: 05/17/2018 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DA	TE SURVEY MPLETED
		245491	B. WING		03	8/29/2018
NAME OF F	PROVIDER OR SUPPLIER	·	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO	DE	
AUGUST	ANA MERCY CARE C	ENTER		710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 677	• • • • • • • • • • • • • • • • • • • •	age 13 ed nursing assistant worksheet	F 67	7		
		Ild be assisted with bathing on				
	stated she did not for available to meet he	on 3/26/18, at 1:59 p.m. R38 Feel there was enough staff er needs. R38 did not know vived a bath, but didn't think it				
		8, Point of Care History report eceived one of two scheduled used the other.				
	R38's February 201 two out of four sche	18, indicated R38 had received eduled baths.				
		Point of Care History report received two out of four nd refused one.				
	was cognitively inta required physical he care plan dated 5/1 with bathing twice a Mondays. An undat worksheet directed	S dated 3/5/18, indicated R56 act, did not refuse cares, and elp in part of bathing. R38's 3/15, directed staff to assist a week on Fridays and ted nursing assistant staff to assist with bathing on an extra bath on Saturdays.				
	stated they are, "Sh bath days will come	on 3/26/18, at 11:22 a.m. R56 nort of help for aides, some e and go without a bath." R56 t get, "Made up," if missed, and g to her.				
	2018, indicated she	e History report for January e had received five of five and two of four Saturday				

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		AND HUMAN SERVICES			FORM	05/17/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245491	B. WING		03/:	29/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA MERCY CARE C	ENTER		710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 677	Continued From pa baths.	ge 14	F 677	7		
	2018, indicated she	e History report for February had received three of four and two of four Saturday				
	2018, indicated she Wednesday baths,	e History report for March had received two of four and no Saturday baths. An rm indicated she had received 3/15/18.				
	had severe cognitiv cares, and required bathing. R60's care extensive assistance	dated 3/2/18, indicated R60 ve impairment, did not refuse I total staff assistance for e plan directed staff to provide ce with bathing on Tuesdays. g assistant worksheet directed in Tuesdays.				
	stated the staff is, "I get a bath on Tueso and set her hair afte pull the bath aide if stated today is Tues had just found out t give baths today. Re	on 3/27/18, at 11:03 a.m. R60 Really short," and she used to day, then they would come in er breakfast. R60 stated they someone calls in sick. R60 sday, and no bath yet, and she hey did not have anyone to 60 stated she does not feel esn't get a bath at least every				
	2018, identified she of the five Tuesdays	e History report for January had received a bath three out s, missing a bath for tween 1/9/18, and 1/30/18.				
		History report for February had received a bath three out				

		AND HUMAN SERVICES			FORM	05/17/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245491	B. WING		03/:	29/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	TANA MERCY CARE C	ENTER		710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 677	Continued From par of four Tuesdays, o R60's Point of Care 2018, identified she on 3/3/18, and 3/4/ ⁷ However, there was report identifying an list dated 3/26/18, id one bath on 3/27/18 The facility's Reside dated February 28, baths being missed When interviewed on nursing assistant (N short staffed, the bath the floor doing nurs the baths do not ge are not able to do the missed. When interviewed of stated the bath aide will try and get the bath usually does not hat When interviewed of stated they do not f	age 15 one she had refused. e History report for March e had received an ordered bath 18, due to scheduled surgery. s no Point of Care History ny other baths. A Master Bath dentified R60 had received 8. No time was identified. ent Council Meeting Notes 2018, noted a concern over d due to staff shortages. on 3/27/18, at 3:47 p.m. NA)-B stated they are often ath aide gets pulled to work on sing assistant duties, and then et done. The nursing assistants hem, and the baths get	F 67	DEFICIENCY)		
	done if they did not When interviewed of stated baths do not don't have time to of When interviewed of stated they can usu	get done on the day shift. on 3/27/19, at 4:02 p.m. NA-D always get done, and they				

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		AND HUMAN SERVICES				FORM	05/17/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245491	B. WING			03/2	29/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	TANA MERCY CARE C	ENTER			10 SOUTH KENWOOD AVENUE IOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677	Continued From page	ge 16	F6	377			
		on 3/28/18, at 7:57 a.m. NA-H e had called in for the day, and t done that day.					
	stated she had offer	on 3/28/18, at 9:22 a.m. NA-I ared to do baths today for her lunteers, "They will get done					
	stated she is often t gets pulled very free	on 3/29/18, at 7:39 a.m. NA-F the assigned bath aide, but quently. NA-F stated she can't I meet everyone's other needs.					
	licensed practical n	on 3/29/18, at 10:40 a.m. ourse (LPN)-A stated she is e nursing assistants with bo busy herself.					
	stated they pull the NA-K stated there w them. NA-K stated s	on 3/29/18, at 7:56 a.m. NA-K bath aide at least weekly. was no way to catch up on sometimes she is asked to p, but not very often.					
	registered nurse (R nursing assistant ca aide from doing bat happens the nursing do all the baths. The the baths have not I Occasionally, a nurs bath had not been of this to the afternoor	sing assistant will report a completed, and she reports n shift so that they can try and llowed up on to see if the					

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		AND HUMAN SERVICES				FORM	05/17/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245491	B. WING			03/:	29/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA MERCY CARE C	ENTER			10 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677	When interviewed of administrator stated baths not always ge addressing the issu and assurance (QA nursing (DON) state they try to get an ex- have a bath aide, o stay late and try to ge A facility policy entit Care dated 7/15, di bath/shower will be each resident, to m resident.	on 3/28/18, at 9:48 a.m. the d the facility was aware of etting done, they are currently ie in their quality assessment (A) committee. The director of ed they are still working on it, dtra person in if they do not r will try and get someone to get the baths done. the Apollo Tub, Basic Nursing rected the frequency of weekly or as requested by eet the hygiene needs of each	F	577			
	had severe cognitiv extensive assistance R214's Social Servi 2/21/18, identified F characteristic(s) inc in her appearance. [activities of daily liv plan dated 3/9/18, it assistance for dress On 3/26/18, at 3:54 have numerous, vis present on her chin neck line. During s 3/27/18, at 7:23 p.n R214 continued to l	Staff assist with ADLs Ving]." Further, R214's care dentified R216 required total sing, bathing, and grooming. p.m. R214 was observed to sible white colored hairs which extended down her ubsequent observations on n. and 3/28/18, at 7:16 a.m. have visible, white colored on her chin and extending					

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245491 B. WING 03/29/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **710 SOUTH KENWOOD AVENUE** AUGUSTANA MERCY CARE CENTER MOOSE LAKE, MN 55767 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 677 Continued From page 18 F 677 When interviewed on 3/28/18, at 9:41 a.m. NA-A stated staff completed R214's grooming for her as there was a lot R214 can't do for herself. NA-A expressed R214 typically did not have facial hair, however, observed her and stated there was some there, which should have been removed during her morning cares. During interview on 3/28/18, at 1:40 p.m. RN-A stated residents should be shaved on their designated bath day(s). RN-A explained R214 did not have any preferences for facial hair, and it should have been removed as residents, "Need to look appropriate." A facility policy on grooming and personal hygiene was not provided. F 684 Quality of Care F 684 5/4/18 SS=D CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced bv: Based on observation, interview and document It is the policy of Augustana Care Moose review, the facility failed to provide assessed Lake Health and Rehabilitation to provide interventions from occupational therapy (OT) to treatment and care in accordance with prevent skin breakdown in a contracted hand for professional standards of practice, the 1 of 5 residents (R214) reviewed for mobility and comprehensive person centered care plan who had limited range of motion (ROM). and the resident choices. Resident R 214 received MD orders for OT evaluation for

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 05/17/2018

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	COM	PLETED
		245491	B. WING _		03/2	29/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
AUGUST	ANA MERCY CARE (CENTER		710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 684	Continued From pa	age 19	F 68	34		
	Findings include:	-		her left hand contracture. E		
	D214's 14 day Mini	imum Data Sat (MDS) datad		completed on 4/23/18, OT r		
		imum Data Set (MDS) dated 214 had severe cognitive		trial of palm protector that w ordered however resident R		
	impairment, and re	quired extensive assistance		discharged from the facility	on 4/24/18.	
		ansfers and personal hygiene.		The facility policy titled Rest		
		a functional limitation in ROM skin lesions, burns or other		nursing programs (RNP)/Fu maintenance programs (FM		
	non-pressure relate			reviewed and revised. All re		
				facility who use splinting de		
		Nursing Communication sheet ified a directive from		reviewed for appropriatenes staff will be re-educated reg		
		by (OT) for, "Lambs wool to		ensure devices and splints	•	
		, daily skin care to be provided		resident's per their plan of c		
		sheet was signed by bist (OT)-A. Further, R214's		DON or designee will audit who use splinting devices p		
		$\frac{1}{28}$ /18, identified an		ensure compliance x4 week		
	intervention directir	ng, "Apply lambs wool to left re to be provided to left hand."		monthly x3 months. Result will be reported to the QAPI review. Corrected by: 5/4/1	s of the audits committee for	
	was laying in bed in contracted left hand muscle) with the fin her palm, causing t	on 3/26/18, at 3:54 p.m. R214 h her room. R214 had a visibly d (shortening and hardening of ngers turned inward, towards the left hand to appear like a ambs wool visible in R214's		Teview. Corrected by. 3/4/1		
	10:19 a.m., 3/27/18 7:16 a.m. R214 wa	observations on 3/27/18, at 3, at 7:23 p.m. and 3/28/18, at s again observed to not have ide or on the left hand as recommendation.				
	and NA-B entered morning cares. R2 assisted to sit in he	5 a.m. nursing assistant (NA)-A R214's room to provide 214 was washed, dressed, and ar wheelchair using a ther of the NA staff provided or				

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		AND HUMAN SERVICES				FORM	05/17/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245491	B. WING			03/:	29/2018
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	TANA MERCY CARE C	ENTER			10 SOUTH KENWOOD AVENUE 100SE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	applied lambs wool these cares, nor wh R214's left hand wa visible cuts, lesions When interviewed of stated she was not wool being used in explained she had nev either. During interview on stated she had nev used on R214's cor staff will provide he like a lamb, and she hand which was no R214 should be tryi her left, contracted therapy recommend and ROM programs resident's closet do them when caring f NA-B and the surve closet door, and NA instructions posted lambs wool to R214 When interviewed of registered nurse (R provides nursing wi post-therapy discha- implemented by nu communication (da directed to insert la contracted left hand NA just brought a c were fearful R214 r	to R214's left hand during hen they were completed. as observed and lacked any or skin damage. on 3/28/18, at 9:09 a.m. NA-A aware of any splints or lambs R214's left hand. NA-A never seen one used prior, a 3/28/18, at 9:50 a.m. NA-B er seen lambs wool being htracted left hand, however, r with a squeeze ball shaped e will often hold it in her other t contracted. NA-B stated ing to use the squeeze ball in hand. Further, NA-B explained dations for splints, devices, s would be placed inside a for so staff could reference for a person. At 12:44 p.m. eyor observed R214's inside A-B verified there were no pertaining to the application of	Fθ	\$84			

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		AND HUMAN SERVICES				FORM	05/17/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245491	B. WING			03/:	29/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA MERCY CARE C	ENTER			10 SOUTH KENWOOD AVENUE IOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684 F 686 SS=D	been used in R214's directed by OT on 3 the NA staff "have to concerns to her soci and coordinated wit can have appropria During interview on stated R214 was un on the left hand due lambs wool should I hand for "protecting breakdown. OT-A e with interventions pu- notify the department "sooner than that [1 "always a risk of [fu skin breakdown. A facility policy on c therapies (PT / OT) splint/device use wa were provided. Treatment/Svcs to F CFR(s): 483.25(b)(1 §483.25(b) Skin Inte §483.25(b)(1) Press Based on the comp resident, the facility (i) A resident receive professional standa pressure ulcers and ulcers unless the im- demonstrates that t (ii) A resident with p necessary treatment	s left hand as had been 8/9/18. Further, RN-A stated o be accountable" and bring oner so they could be clarified th therapy adding, "Then we te care for the resident." 3/29/18, at 11:16 a.m. OT-A hable to use a palm protector to the contracture. The have been placed in the left g the skin" and preventing skin explained if staff had concerns rovided by OT, they should nt to have them addressed 9 days later]" as their was rther] decline" in ROM and coordination of care with and/or contracture as requested, however, none Prevent/Heal Pressure Ulcer 1)(i)(ii) egrity sure ulcers. rehensive assessment of a must ensure that- es care, consistent with ard so f practice, to prevent d does not develop pressure dividual's clinical condition they were unavoidable; and oressure ulcers receives at and services, consistent	F 6				5/4/18
	necessary treatmen						

Facility ID: 00049

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		E & MEDICAID SERVICES	0.00			0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		E SURVEY PLETED
		245491	B. WING		03/2	29/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
AUGUST	ANA MERCY CARE	CENTER		710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 686	Continued From pa	age 22	F 680	6		
	promote healing, p new ulcers from de This REQUIREME by:	revent infection and prevent eveloping. NT is not met as evidenced				
 Based on observation, interview, and do review, the facility failed to provide timely assistance with repositioning to promote and prevent development of new pressur for 1 of 1 (R17) residents reviewed with o pressure ulcers. Findings include: R17's quarterly Minimum Data Set (MDS 1/5/18, included diagnoses of cardiovasc disease, diabetes mellitus type 2, chronic disease, and peripheral vascular disease MDS indicated no cognitive impairment, extensive assistance with activities of da (ADLs), no rejection of cares and no presulcers. R17's annual MDS dated 7/7/17, indicate cognitive impairment, extensive assistance with activities of da (ADLs), no rejection of cares and no presulcers. R17's annual MDS dated 7/14/17, indicate cognitive impairment, extensive assistance with activities of backers. R17's annual MDS dated 7/14/17, indicate cognitive impairment, extensive assistance with activities of the pressure Ulcer Care Area Assessment (CAA) dated 7/14/17, indicate riggered due to extensive assistance wit mobility, frequently incontinent of bladder risk for skin alterations. R17 scored 15 o Braden Scale (tool used to predict pressure The CAA also indicated R17 could be non-compliant with repositioning. Staff w turn and reposition every 2 hours, and pr air mattress on the bed. 	failed to provide timely positioning to promote healing opment of new pressure ulcers		It is the policy of Augustana Lake that a resident entering without pressure injuries doe pressure injuries unless the clinical condition demonstrat were unavoidable; and to pre and services consistent with	the facility as not develop individual's tes that they ovide care		
	R17's quarterly Mir 1/5/18, included dia disease, diabetes r disease, and perip MDS indicated no extensive assistan (ADLs), no rejectio	agnoses of cardiovascular mellitus type 2, chronic kidney heral vascular disease. The cognitive impairment, ce with activities of daily living		standards of practice to pror prevention of pressure injury development, promote the h existing pressure injuries an the development of additiona injuries. Resident R17 was hospitalized from 3/8/18-3/12 return from the hospital she have a Stage one pressure in right buttock measuring; 4.5 this was an area of delayed (redness). In addition she w	ealing of d to prevent al pressure s noted to be 3/18, upon was noted to njury to her x4.0cm in size blanching	
	cognitive impairmed ADLS, no rejection ulcers. The Pressu Assessment (CAA triggered due to ex mobility, frequently risk for skin alterat Braden Scale (tool risk) placing reside The CAA also indic non-compliant with turn and reposition	ent, extensive assistance with of cares and no pressure ire Ulcer Care Area) dated 7/14/17, indicated CAA (tensive assistance with r incontinent of bladder, and at ions. R17 scored 15 on the used to predict pressure ulcer ent at risk for pressure ulcers. cated R17 could be repositioning. Staff were to every 2 hours, and provide an		have two areas of abrasion; right buttocks measuring; 3. left buttocks abrasion measu 0.5x2.5cm these two areas noted to be pressure ulcers. Comprehensive skin assess completed upon her hospital with interventions put in place prevent/heal any skin conce resident is noted to have a h refusing repositioning while bed, she is noted to have a s versus benefit in her chart th the risks of refusing reposition	one to her 0x3.5cm and uring; were not ment was return 3/8/18 e to help rns. The istory of in her w/c or signed risk nat includes	

Facility ID: 00049

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COMPLE 03/29/ 03/29/ DBE RIATE	
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R17 8 hours.	
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ecord. ee weekly	
across a	
be	
	n d. All ers and d to g ling nent all ecord. ee weekly ned across a

		AND HUMAN SERVICES				FORM	05/17/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245491	B. WING			03/:	29/2018
NAME OF	PROVIDER OR SUPPLIER			SI	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
AUGUST	ANA MERCY CARE O	ENTER			10 SOUTH KENWOOD AVENUE IOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	Continued From pa	ige 24	F 6	86			
	her room next to be stated she was up of stated she had sore were better. - At 7:20 a.m. R17 position. - At 7:40 a.m. R17 asleep in her wheel - At 8:10 a.m. same - At 08:26 a.m. same - At 08:20 a.m. R17 room. Eating indep - At 9:00 a.m. R17 -At 9:20 a.m. NA-H when R17 was last NA-H stated the nig repositioned her wh morning cares, and wheelchair. NA -H for toileting or repose work at 6:00 a.m. - At 9:30 a.m. R17 refused to be repose reported to licensed R17 refused to be repose repose to be r	e position. The position. The social worker in to notify her of an upcoming was served breakfast in her endently. was done with breakfast. I was interviewed regarding assisted with repositioning. ght staff would have then they assisted her with I transferred her into the verified she had not checked sitioning since she started had company visiting, and sitioned or toileted. NA-H d practical nurse (LPN)-B that repositioned. LPN-B spoke continued to refuse. LPN-B lained the importance of g pressure to an area) but R17 ay allow at 10:00 a.m. ated R17 can get feisty and A-H verified R17 should be ioned every 2 hours, and R17 her buttocks that are					

Facility ID: 00049

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	05/17/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245491	B. WING	;		03/:	29/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
AUGUST	TANA MERCY CARE C	ENTER			10 SOUTH KENWOOD AVENUE IOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	 At 11:38 a.m. NA-H repositioned and to NA. On 3/29/18, at 07:4 bed awake. R17 wa with a pillow behind At 8:01 a.m. obser perform morning ca completed R17's sk hospital return, and much improved. R1 observed pressure buttocks. A very sm observed to the left buttocks was heale observed to have a RN-C stated the wo PU today. R17's Weekly Wou - 03/14/18, Readmi completed. Resider scale. Resident is r on buttocks. Resider scale. Resident is r on buttocks. Resider sacral, coccyx or bu minimize time in be daily. Pressure redu [wheelchair]; pressu- bed. Continue to fo Assess skin folds fo by care provider. N weekly. Complete a pressure areas of co 	H stated R17 was finally bileted at 11:00 a.m. by another 45 a.m. R17 was observed in as positioned on her right side d her lower back. Twed RN-C/Nurse Educator ares. RN-C stated she kin assessment upon a recent d her pressure ulcers were 17 was turned on side and ulcer (PU) to the right hall scabbed open area was t buttocks. The PU to the right ed. R17's wheelchair was a pressure relieving cushion. bund nurse would measure the	F	686			

Facility ID: 00049

If continuation sheet Page 26 of 50

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	CO	MPLETED
		245491	B. WING		03	/29/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 710 SOUTH KENWOOD AVENUE	DE	
AUGUST	ANA MERCY CARE O	CENTER				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 686	Notify MD [medical as appropriate. Col - 03/14/18, able to this time r/t [related readmission follow of LLE [left lower et have an area to he 4.5 cm [centimeters	age 26 doctor/NP [nurse practitioner] ntinue with plan of care. assess resident's buttocks at I to] indication of open sores r/t ing hospitalization r/t cellulitis xtremity]. Resident is noted to r right (R) buttock measuring s] x 4.0 cm of darkened ed blanching [Stage 1] with a	F 68(0		
	noted area of abras cm x 3.5 cm. Area granulation; no evid tunneling, undermin current s/sx of infec Previous other ope scabbed to the sup area. Left (L) buttoo with abrasion area with pink/red granu undermining, tunne infection. Surround permanent staining blanchable skin. Re	sion within area measuring 3 presents with pink/red dence of slough or eschar, no ning, sinus tracts, induration or ction. No exudate noted. n areas are noted to be perior location of the abrasion cks superior medial location measuring 0.5 cm x 2.5 cm lated tissue. No evidence of eling, sinus tracts or s/sx of ing skin presents with of darkened purplish esident does not present with				
	bilateral buttocks, a then apply skin bar to be on ABx [antib - 3/27/18, able to a afternoon. Residen her (R) buttock me redness with delay abrasion that was p present to area. An granulation; no evic	ment. Treatment: wash apply skin prep allow to dry and rier cream. Resident continues iotic] r/t infection. ssess resident's buttocks this it is noted to have an area to asuring 2.0 cm x 2.0 cm of ed blanching [stage 1]; previously noted is no longer ea presents with pink/red dence of slough or eschar, no ning, sinus tracts, induration or				

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		AND HUMAN SERVICES				FORM	05/17/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245491	B. WING	i		03/2	29/2018
NAME OF I	PROVIDER OR SUPPLIER		-	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	TANA MERCY CARE C	ENTER			10 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	area that is now sca x 1.2 cm. No evider sinus tracts or s/sx presents with perm purplish blanchable present with pain di wash bilateral butto dry and then apply - 3/29/18, at 1:45 p. buttocks this aftern an area to her (R) b 1.4 cm of slight red [stage 1]; abrasion no longer present to have area of drying buttocks with was e of the area. Area pr epithelialization; no no tunneling, under or current s/sx of in buttocks superior m area that was previ is now considered f scabbing noted to a presents with perm purplish blanchable present with pain di continue to follow a present to area, will time. Treatment: wa skin prep allow to d cream. On 3/29/18, at 12:1 verified the care pla repositioning every expect staff to prov	abbed over measuring 0.8 cm nce of undermining, tunneling, of infection. Surrounding skin anent staining of darkened skin. Resident does not uring assessment. Treatment: ocks, apply skin prep allow to	F	686			

Facility ID: 00049

If continuation sheet Page 28 of 50

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION		E SURVEY
ID PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	CON	1PLETED
		245491	B. WING		03/	29/2018
IAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE	
UGUST	ANA MERCY CARE C	ENTER		710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORI X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 686	Continued From pa	ge 28	F6	86		
		ssure ulcers after a recent beginning of March, which are				
F 688 SS=D	not provided by the	ecrease in ROM/Mobility	F 6	88		5/4/18
	resident who enters range of motion do range of motion unl	facility must ensure that a the facility without limited es not experience reduction in less the resident's clinical ates that a reduction in range				
	motion receives ap services to increase	ident with limited range of propriate treatment and e range of motion and/or to rease in range of motion.				
	receives appropriat assistance to maint the maximum pract reduction in mobility	ident with limited mobility e services, equipment, and tain or improve mobility with ticable independence unless a y is demonstrably unavoidable. NT is not met as evidenced				
	Based on observat review, the facility fa interventions to ma	tion, interview, and document ailed to follow care planned intain or improve range of sidents (R60) reviewed for		It is the policy of Augustana Lake Health and Rehabilitation that a resident who enters the without limited range of motion experience a reduction in rare unless the resident's clinical	on to ensure e facility on doesn't age of motion	
	Findings include:			demonstrates that a reductio of motion is unavoidable. In		
	R60's Face Sheet u	undated, indicated diagnoses		the policy of Augustana Care	Moose Lake	

Facility ID: 00049

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TATEMEN	RS FOR MEDICARE OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY
	OURCEIIUN	DENTIFICATION NUMBER.	A. BUILDIN	G		
		245491	B. WING		•	29/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE	
AUGUSI	ANA MERCY CARE O	ENTER		710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 688	Continued From pa	ige 29	F 68	8		
	included aphasia (lit the production or or hemiplegia (paralys hemiparesis (weak body) following cere R60's annual Minim 3/2/18, indicated R0 rarely or never und extensive assistant dressing, and perso identified functional (ROM) of upper (sh hand) and lower ex and foot). R60's Care Area As (activities of daily lin R60 required exten mobility, transfers, grooming, and total also indicated R60 eating, and directed R60's Physician Or revealed an order f except during hygic every shift and pas to the right fingers, patient tolerance 10 and evenings). R60's care plan dat to maintain current increase ROM in rig interventions direct PROM to right upper	anguage impairment affecting omprehension of speech), sis of one side of the body and ness of the entire side of the ebral infarction (stroke). hum Data Set (MDS) dated 60 had no rejection of cares, erstood, and required ce for bed mobility, transfers, onal hygiene. The MDS also I limitation in range of motion noulder, elbow, wrist, and tremities (hip, knee, ankle, seessment (CAA) for ADLs ving) dated 3/12/18, indicated sive assistance with bed locomotion, dressing, toileting, I assist with bathing. The MDS required supervision with d to proceed to the care plan. der Report dated 3/29/18, or right hand splint at all times, ene when needs to be washed, sive range of motion (PROM) wrist, elbow and shoulder to D repetitions twice a day (days ted 12/01/17, identified a goal ROM in upper extremity or ght upper extremity. The ed staff to provide gentle er extremity, shoulder, elbow, splint at all times except for		Health and Rehabilitation to residents receive appropria and equipment to maintain mobility. Resident R60 was Occupational therapy on 4/, following recommendations Protector is recommended Resident R60 has been not history of refusing to wear h and throwing it in the garba plan was updated to include wear the palm protector. will be re-educated on appl splints/braces and need to are applied per the care pla policy and procedure for Re nursing programs (RNP)/For maintenance programs (FN reviewed and revised. The and procedure for PROM a reviewed and updated. All the facility will be assessed appropriateness and or need of motion program. In addi staff will receive training on procedure PROM and ARC The DON or designee will a resident ROM programs we then monthly x3 months to compliance. Results of aud reviewed by the facility QAF Corrected by: 5/4/18.	te services or improve s evaluated by 23/18 with the s; Palm for the RUE. ted to have a her hand splint ge. R60s care e refusals to Nursing staff ication of ensure they an. The Facility estorative unctional <i>NP</i>) has been facility policy and AROM was residents in for ed for a range tion all nursing the policy and <i>M</i> programs. audit three eekly x4 weeks ensure dits will be	

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	LTH AND HUMAN SERVICES ARE & MEDICAID SERVICES				FORM	: 05/17/2018 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
	245491	B. WING	;		03/	29/2018
NAME OF PROVIDER OR SUPPL	LIER		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
AUGUSTANA MERCY CA	RE CENTER			10 SOUTH KENWOOD AVENUE IOOSE LAKE, MN 55767		
PREFIX (EACH DEFICI	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
frequently.R60's group sh indicated right H hygiene and wh ROM program: shoulders, PRO repetitions.R60's Restorati PROM to right to tolerance, 10 and p.m.) was to 1/1/18- 1/31/18 2/1/18- 2/28/18 3/1/18- 3/28/18During observati was seated in H member (FM)-/ right hand (sho with the fingers causing left har no splint in R60During interview stated R60 had the right side, a FM-A further st was observed for NA-H stated sh clothes on, was bath," and assis bed to wheelch	ated R60 refused to wear splint neet (nursing assistant instruction hand splint at all times except for hen needs to be washed, and right fingers, wrist, elbow, and OM to tolerance a.m. and p.m., 10 tive Nursing records indicated fingers, wrist, elbow and shoulde D repetitions twice daily (in a.m. not consistently provided: - missed 14 times - missed 14 times - missed 6 times ation on 3/27/18, at 10:54 a.m. R6 her wheelchair, visiting with family A. R60 had a visibly contracted ortening and hardening of muscle s turned inward, towards palm, nd to appear like a fist. There wa	s)) r, ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ;	688			

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		AND HUMAN SERVICES				FORM	05/17/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATE	E SURVEY PLETED
		245491	B. WING			03/:	29/2018
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	TANA MERCY CARE O	ENTER			IO SOUTH KENWOOD AVENUE OOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	Continued From par room. R60 was obs fingers inward towar During subsequent 9:00 a.m. R60 was wheelchair in her roo on R60's right hand NA-H asked R60 is nodded no. NA-H the not want to wear the During interview on stated she consister range of motion exer resident lays down stated she tried to o at least once a day, have time. NA-H star right hand splint for remove the group s acknowledged the g hand splint on at all when needs to be w On 3/29/18, at 9:19 room and attempter was not able to find When interviewed of registered nurse (R black hand splint. F was hiding or puttin	age 31 served to continue to hold ards palm, forming a fist. observation on 3/29/18, at observed to be up in her bom, no splint was observed d. NA-H was also in the room, a she wore a hand splint, R60 hen asked resident if she did e splint, and R60 nodded yes. 3/29/18, at 9:08 a.m. NA-H ently works with R60 and does ercises in the afternoon, as after lunch. NA-H further do twice a day ROM, but does , and that she just doesn't ated she had never seen a R60. NA-H proceeded to sheet from her pocket, and group sheet indicated right I times except for hygiene, and washed.	F 6	888			
	washcloth in her rig accepting a washcl recently notified the requested the phys	ne point they were putting a ght hand because she was oth." RN-B further stated she e physician on 3/27/18, and ician discontinue the hand rted they did not have the right					

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		AND HUMAN SERVICES			FORM	05/17/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245491	B. WING		03/	29/2018
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	-	
AUGUST	ANA MERCY CARE C	ENTER		10 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 688	had been on the ca was unable to deter been missing. RN-F implementation of t programs were eva manager. RN-B exp included nursing as refusals, program in determination if still summary note was to find a recent qua quarterly note comp did not address the On 3/29/18, at 1:52 her wheelchair in he washcloth was obse attempted to open it. I put a washcloth her RN-B indicated cou in R60's hand. The PROM and AR policy dated 6/2016 limitations in function plan of care, notify therapy as indicated PROM may be com- independent nursin order, perform ROM indicated in the rest document PROM d record, document of and notify MD.	ondicated the right hand splint re plan since 4/17/17, and rmine how long the splint had 8 explained the he PROM, ROM, and walking luated quarterly by the nurse oblained the review process asistant charting, resident mplementation frequency, beneficial for resident, then a completed. RN-B was unable rterly summary note; the last obleted was dated 9/14/17, and right hand splint. p.m. R60 was observed in er room. No right splint or erved in hand. RN- B R60's hand and was only able RN-B asked R60 if she could r hand and R60 nodded yes. Id, "Definitely" put a washcloth OM (active range of motion) 6, directed staff to identify onal ability on the resident's the physician and/or physical d. The policy further directed opleted by nursing staff as an g function and/or physician M exercises as ordered or torative nursing program, one on electronic treatment changes in functional statues,	F 688			
F 689 SS=D	•	azards/Supervision/Devices 1)(2)	F 689			5/4/18

		& MEDICAID SERVICES			<u>OMB NO.</u>	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
		245491	B. WING		03/2	29/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA MERCY CARE (CENTER				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 689	Continued From pa	age 33	F 68	9		
	as free of accident §483.25(d)(2)Each supervision and as accidents. This REQUIREME by: Based on observa review, the facility f interventions for 1 of for accidents. Findings include: R47's Face Sheet of diagnoses of peripl (narrowing of artering flow), type 2 diabet of intertrochanteric fracture. R47's quarterly Min 2/21/18, identified f with no injury since limited assistance of extensive assistance			It is the policy of Augustana Car Lake Health and Rehabilitation to that the resident's environment r as free of accident hazards as po and that each resident receives a supervision and assistance devic prevent accidents. Resident R43 strips were replaced next to her they had been removed during fl maintenance. A new fall risk observation that the grip strips remain approphelp prevent falls related to slipp addition the fall risk observation indicate that the resident needed supervised while in the bathroom is able to use her call light to call while on the toilet this was remov- her care plan. Augustana policy Accident Prevention and Reduct	ensure emains ossible adequate ces to 7's grip bed as bor ervation dicated oriate to ng. In didn't to be for assist yed from titled	
	was cognitively inta R47's Care Area As dated 6/5/17, indica falls. The CAA iden falls included intern	e. The MDS also identified R47 act. ssessment (CAA) for falls ated R47 was at high risk for ntified R47's risk factors for nittent confusion and altered sfers, resists using the call		was not requested during survey reviewed and remains appropria facility staff will be educated rega need to ensure that all residents strips in place per care plan. All in the facility will be reviewed to e risk interventions including grip s remain appropriate and to ensure	e. All arding have grip residents ensure fall trips	

Facility ID: 00049

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RECTION DER OR SUPPLIER MERCY CARE (IDENTIFICATION NUMBER: 245491	B. WING	3	СОМ	PLETED
	245491				
				03/2	29/2018
MERCY CARE O			STREET ADDRESS, CITY, STATE, ZIP CODE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767		
EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
refuses staff a aviors, occasion der, and require sfers and all AL s known to refu- required black and in front of room, sign in re- ight, observe fo- ictions, and dir s care plan dar gh risk for falls ired safety aw- ventions inclue of bed and in f ot leave reside (17), place sign ourage use of co- frame becaus group sheet (re- ated, indicated on t leave una s progress not erienced four fa- n 12/27/17, sta	assistance, wandering nally incontinent of bowel and es assistance of one with DLs (activities of daily living), use cares. The CAA indicated grip strips to the floor side of toilet, do not leave alone in oom to remind resident use or unsafe actions, remind of rected to proceed to care plan. ted 3/5/18, indicated R47 was , and she was noted to have areness. The care plan led black strips added to floor front of toilet (dated 1/27/17), int alone in bathroom (dated n on her closet door to call light, falling leaf magnet on e resident was at high risk for hursing assistant instructions) for toileting "A-1 [assist of one] attended in bathroom." es indicated resident alls in the last 6 months: aff heard R47 call out, "Help."	F 689	compliance. Resident rooms will audited following unit cleans to en grip strips are present along with care planned safety interventions. DON or designee will audit three n per week x4 then monthly x3 mon ensure compliance with care plan safety interventions. Results of an be reported to the facility QAPI	sure all other The residents ths to ned	
	inued From parefuses staff a viviors, occasio der, and requir sfers and all AL s known to refu- required black and in front of room, sign in r ight, observe fri- ictions, and dir s care plan da gh risk for falls ired safety aw ventions inclue of bed and in f ot leave reside (17), place sign ourage use of c frame becaus group sheet (r ted, indicated o not leave una s progress not rrienced four far n 12/27/17, stan n arrival, R47 v oot of her bed. said that she v	inued From page 34 refuses staff assistance, wandering wors, occasionally incontinent of bowel and der, and requires assistance of one with ofers and all ADLs (activities of daily living), is known to refuse cares. The CAA indicated required black grip strips to the floor side of and in front of toilet, do not leave alone in room, sign in room to remind resident use ight, observe for unsafe actions, remind of ictions, and directed to proceed to care plan. s care plan dated 3/5/18, indicated R47 was gh risk for falls, and she was noted to have ired safety awareness. The care plan ventions included black strips added to floor of bed and in front of toilet (dated 1/27/17), ot leave resident alone in bathroom (dated /17), place sign on her closet door to ourage use of call light, falling leaf magnet on frame because resident was at high risk for group sheet (nursing assistant instructions) ited, indicated for toileting "A-1 [assist of one] o not leave unattended in bathroom." s progress notes indicated resident rienced four falls in the last 6 months: n 12/27/17, staff heard R47 call out, "Help." n arrival, R47 was found to be on the floor at oot of her bed. When asked what happened, said that she was trying to get to the room and lost her balance. R47 was	inued From page 34 refuses staff assistance, wandering wors, occasionally incontinent of bowel and der, and requires assistance of one with sfers and all ADLs (activities of daily living), s known to refuse cares. The CAA indicated required black grip strips to the floor side of and in front of toilet, do not leave alone in room, sign in room to remind resident use ight, observe for unsafe actions, remind of ictions, and directed to proceed to care plan. s care plan dated 3/5/18, indicated R47 was gh risk for falls, and she was noted to have ired safety awareness. The care plan ventions included black strips added to floor of bed and in front of toilet (dated 1/27/17), ot leave resident alone in bathroom (dated (17), place sign on her closet door to ourage use of call light, falling leaf magnet on frame because resident was at high risk for group sheet (nursing assistant instructions) ited, indicated for toileting "A-1 [assist of one] o not leave unattended in bathroom." s progress notes indicated resident reienced four falls in the last 6 months: n 12/27/17, staff heard R47 call out, "Help." n arrival, R47 was found to be on the floor at oot of her bed. When asked what happened, said that she was trying to get to the	DEFICIENCY) inued From page 34 refuses staff assistance, wandering wiors, occasionally incontinent of bowel and der, and requires assistance of one with fers and all ADLs (activities of daily living), s known to refuse cares. The CAA indicated required black grip strips to the floor side of and in front of toilet, do not leave alone in room, sign in room to remind resident use ight, observe for unsafe actions, remind of ictions, and directed to proceed to care plan. s care plan dated 3/5/18, indicated R47 was gh risk for falls, and she was noted to have ired safety awareness. The care plan ventions included black strips added to floor of bed and in front of toilet (dated 1/27/17), ot leave resident alone in bathroom (dated '17), place sign on her closet door to urage use of call light, falling leaf magnet on frame because resident was at high risk for group sheet (nursing assistant instructions) ted, indicated for toileting "A-1 [assist of one] o not leave unattended in bathroom." s progress notes indicated resident wrienced four falls in the last 6 months: n 12/27/17, staff heard R47 call out, "Help." n arrival, R47 was found to be on the floor at oot of her bed. When asked what happened, said that she was trying to get to the	DEFICIENCY) DEFICIENCY) inued From page 34 refuses staff assistance, wandering words, occasionally incontinent of bowel and der, and requires assistance of one with fers and all ADLs (activities of daily living), s known to refuse cares. The CAA indicated required black grip strips to the floor side of and in front of toilet, do not leave alone in room, sign in room to remind resident use gight, observe for unsafe actions, remind of ictions, and directed to proceed to care plan. s care plan dated 3/5/18, indicated R47 was gh risk for falls, and she was noted to have ired safety awareness. The care plan ventions included black strips added to floor of bed and in front of toilet (dated 1/27/17), to leave resident alone in bathroom (dated 1/17), place sign on her closet door to urage use of call light, falling leaf magnet on frame because resident was at high risk for group sheet (nursing assistant instructions) ted, indicated for toileting "A-1 [assist of one] o not leave unattended in bathroom." s progress notes indicated resident trienced four falls in the last 6 months: n 12/27/17, staff heard R47 call out, "Help." n arrival, R47 was found to be on the floor at oot of her bed. When asked what happened, said that she was trying to get to the

		AND HUMAN SERVICES			FORM	05/17/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245491	B. WING		03/	29/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA MERCY CARE C	ENTER		710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI ((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	Continued From pa good, and R47 had 2. On 1/08/18, staff they went in room, b between her bed ar on her right side/ba complained of pain she hit it when she head. R47 stated sl wheelchair to go to gripper socks on. R and the call light wa Staff reminded R47 she needed to get u 3. On 2/22/18, R47 in her room. R47 wa feet facing her nigh was trying to turn of When asked R47 w stated she did not k of discomfort or pa noted when reposit in all four extremitie 4. On 3/3/18, staff v wheelchair in her ro at the time of the fa (on right side) agair nightstand. R47 sta into bed. R47 had r discomfort. ROM in normal. During interview on stated staff want her help, and make sur wheelchair. R47 po door that directed "		F 68	DEFICIENCY)		
	indicated she had n					

Facility ID: 00049

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 09 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SU COMPLEX	SURVEY
245491 B. WING 03/29/	9/2018
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
AUGUSTANA MERCY CARE CENTER 710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CG TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE CG	(X5) COMPLETION DATE
F 689 Continued From page 36 F 689 was observed sitting in her wheelchair in the middle of her room, head held down, arms dangling on both sides of wheelchair. No black strips was observed on the floor side next to R47's bed. During subsequent observation on 3/28/18, at 9:33 a.m. R47's bathroom call-light was observed to be on. Nursing assistant (NA)-H was observed to enter R47's room. R47 was up in her wheelchair in the bathroom. NA-H asked R47 if she needed to go to the bathroom. NA-H proceeded to assist R47 with transferring from her wheelchair to the toilet. NA-H then closed the door and left the room. At 9:37 a.m. the bathroom call-light was standing in the hallway, outside of R47's room, went into R47's room, and assisted R47 to transfer from the toilet to the wheelchair. During interview on 3/28/18, at 9:33 a.m. NA-H stated R47 will go in to the bathroom inthe toilet to the wheelchair. During interview on 3/28/18, at 9:33 a.m. NA-H stated R47 will go in to the bathroom gift when she is finished. NA-H further indicated R47 often self transferred, staff answer the call-light as soon as the light goes on, and inform R47 to use the call-light and refrain from self transferring. On 3/29/18, 8:46 a.m. R47 was not in her room. No black strips was observed on the floor side next to R47's bed. When interviewed on 3/29/18, at 9:29 a.m. registered nurse (RN)-B stated R47's level of alertness varies, and R47 often self transferred in and out of bed, will put the call-light on to get onto the toilet. RN-B further stated R47 has som as done on the ciall, R47 to three stated R47 has som as done on the cialler. RN-B turther stated R47 has som as done on the cialler. RN-B turther stated R47 has som as done on the ciall light when she was done on the ciallight when she was done on	

If continuation sheet Page 37 of 50

DEPARTMENT OF HEALTH AND HUMAN SERVICES		RINTED: 05/17/2018 FORM APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING	INSTRUCTION	ABNO. 0938-0391 (X3) DATE SURVEY COMPLETED
245491 B. WING		03/29/2018
NAME OF PROVIDER OR SUPPLIER STREET	T ADDRESS, CITY, STATE, ZIP CODE	
L AUGUSTANA MERCY CARE CENTER	OUTH KENWOOD AVENUE SE LAKE, MN 55767	
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIXTAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
F 689 Continued From page 37 F 689 mostly by her bed. RN-B acknowledged the care plan directed staff to not to leave R47 alone in the bathroom, "Definitely something I need to discuss with the team." RN-B further indicated R47 should have black strips on the floor next to her bed. At 12:27 p.m. R47's room was reviewed, RN-B confirmed there were no black strips on the floor next to R47's bed. RN-B indicated R47 had resided in current room since 4/17. A policy regarding fall protocols was requested but not provided. F 725 Sufficient Nursing Staff F 725 SS=E CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident asfety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurse; and (ii) Other nurse gides. 	DEFICIENCY)	5/4/18

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		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		<u>. 0938-039</u> E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:		NG		IPLETED
		245491	B. WING _		03/	29/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA MERCY CARE C	ENTER		710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 725	• · · · · · · · · · · · · · · · · · · ·	ge 38 pt when waived under	F 72	25		
	paragraph (e) of thi designate a license nurse on each tour This REQUIREMEN by: Based on observat review, the facility fa enough staff availal R5, R12, R13, R15, and R265) interview assistance they nee was often not timely NA-C, NA-A, NA-D, LPN-A, NA-K, RN-A had concerns abour meet residents nee Findings include: R3's admission Min 12/18/17, indicated not refuse cares, re with toileting, and w staff to bathe. Whe 3:05 p.m. R3 stated staff." R3 went on to get up in the mornin this creates a proble bathroom and can't incontinent which is stated there was no she gets a bath even	s section, the facility must d nurse to serve as a charge of duty. IT is not met as evidenced ion, interview, and document ailed to ensure there was ole for 11 of 18 residents (R3, R17, R38, R56, R60, R62, wed who did not receive the eded, or felt the assistance 7. In addition, 12 of 16 (NA-B, NA-G, NA-H, NA-I, NA-F, A, and NA-E) staff members t not having enough staff to ds timely. imum Data Set (MDS) dated R3 was cognitively intact, did quired extensive assistance ras totally dependent upon two on interviewed on 3/26/18, at l, "They are always short of o say she has had to wait to ng until more people arrive, em when she has to go to the hold it. She then becomes upsetting to her. R3 also at enough staff to make sure ery week. History report indicated she rekly baths since January 1, 11 days without a bath		It is the policy of Augustana Ca Lake Health and Rehabilitation that the facility employee's suff nursing staff with the appropria competencies and skills to prov nursing services that meet the the resident population. The F Resource Assessment was rev updated related to staffing. Th plan is noted to be a suggested will be adjusted as needed. Ma staff will use a multifactorial ap staffing that includes review of resident acuity, physical plant s budget, mix of available staff at the needs of resident care. Sta be adjusted to ensure patient of care by all available staff not lir nursing assistant and licensed interdisciplinary approach will b Staffing direction will be given b Administrator/DON or designed absence and reviewed on a da and adjusted as needed. Work the building were evaluated reg bathing and new bath schedule revised and implanted on a hou basis. If for any reason, a bath missed it will be scheduled for day to ensure preferences of fr baths/showers is attained. The as a freestanding position will b	to ensure cient te vide needs of acility Wide iewed and s staffing I plan that anagement oroach for census, tructure, nd meeting offing will entered nited to staff but an e used. by the e in their Iy basis a flows of larding s were use wide /shower is the next equency of bath aide	

Facility ID: 00049

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUI	TIPLE CONSTRUCTION	OMB NO.	E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:		NG	· · ·	PLETED
		245491	B. WING		03/2	29/2018
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
AUGUST	ANA MERCY CARE C	ENTER		710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 725	Continued From pa	ige 39	F 7	25		
F 725	R5's quarterly MDS was cognitively intar required extensive toileting and total st When interviewed of stated there was no needs timely. She she wakes up she in commode right awa minutes for someon holding in the urine the commode she if also had a concern bath, which she stat bathing, but needs breasts and abdom History report indica bath once each mo had refused two of scheduled weekly f R12's annual MDS was cognitively intar required one perso ambulation and bat 1/1/18, indicated stat assist with a shower interviewed on 3/27 she has GERD (gat and she will put on	a dated 12/19/17, included R5 ict, did not reject cares, assistance from staff for taff assistance with bathing. on 3/26/18, at 11:48 a.m. R5 ot enough staff to meet her stated in the morning when needs to go to use the ay, it often takes 15 to 20 ne to come, and by then is painful. Once she gets to then has trouble urinating. R5 about not getting a weekly ited she typically does not like to due to skin concerns under inal folds. R5's Point of Care ated she had only received a onth since January 1, 2018. R5 the baths which were	F 7	 25 nursing assistant assignment nursing assistants will perfer assigned resident's baths performent of a proper schedule and resident wish functional maintenance provide a signed for appropring nursing-therapy review as a longer pertinent or appropring current resident status. All were updated accordingly. reviewed on an ongoing ba quarterly reviews as a focu addition the facility will confiree reutiment and retention erecruitment and retention and colleg visits, Job fairs ranging from to the Metro Retention Bonus up to Outside the box events fairs that are a Pizza party Chris events at the local complexity of the erecruitment and external recruitment an	orm their ber revised les. All ograms (FMPs) ateness with a many were no iate of the care plans FMPs will be sis with the sed area. In tinue fforts aimed at ployees as ent efforts een and azz as a others eed. e informational Duluth/Superior \$3000 s such as job or coffee with ffee shops	
	is really uncomforta concern that she w ambulation every d	o not come right away and this able for her. R12 expressed as not being assisted with ay, she is at risk for falling, so		for C.N.A. individuals only.resource was added to attrijob seeker.Adapting to the job ma	act the passive rket and	
	upsetting to her. R5	r. R12 stated this was 5's Point of Care History he had missed 12 of the twice		understanding it has been effort for Augustan. We ha formally analyzing the work 2014 when we received a	ve been force since	

Facility ID: 00049

		AND HUMAN SERVICES				FORM	05/17/201 APPROVE 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION		E SURVEY PLETED
		245491	B. WING			03/2	29/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA MERCY CARE C	ENTER			10 SOUTH KENWOOD AVENUE IOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 725	was cognitively inta was totally depended care plan dated 11/ extensive assistance assist for dressing, praise him for partie undated nursing as R13 should be assis When interviewed of stated he is suppose but there is not end if there is a bath aid giving baths much R13 stated he knew this happened quite of when he had or l scheduled bath. In been, "Really short only having one nur on the wing, usually that is not even end that he is capable of staff do it for him as R13's Point of Care missed 13 twice a w 2018. R15's quarterly MD had moderate cogn cares, required extra activities of daily liv dependent upon sta	dated 12/30/17, indicated he ict, did not reject cares, and ent upon staff to bathe. R13's 4/15, indicated he required ce for bathing and extensive staff were to encourage and cipation in dressing. An sistant worksheet indicated sted with a bath twice a week. on 3/26/18, at 1:10 p.m. R13 sed to get a bath twice a week, ugh staff on. R13 stated even de on, they get pulled from of the time to do other things. v he missed a bath last week, e often, but had not kept track had not received the addition, R13 stated they have of staff," lately sometimes rse aide for the 22 residents v have two nurse aides and ough. R13's other concern was of dressing self with set up, but is they are in, "Such a hurry." e History showed he had week baths since January 1, S dated 1/2/18, indicated R15 hitive impairment, did not reject ensive assistance for most ing (ADLs) and was totally aff for bathing. R15's care o provide two baths per week.	F 7	25	from the Northland foundation. The this project we adopted additional recruitment efforts in different forma established an on-site C.n.A. trainin course which eventually resulted in on-site certified trainers. The 2017 workforce grant from Leading Age I deepened our understanding of our current workforce and how to create retention driven environment for the do attract. • We have established partnersh with the area colleges, schools, and health care community. Examples these partnerships: • Clinical site for FDLC nursing students and East Central C.N.A. of • One of our current C.N.A. instru- is an adjunct instructor for FDLC te a site based Health Occupation course/C.N.A class; • Active participant on the Nursin Advisory board and National accred for PTCC • Currently speaking with Americ Cross representative to host Northe C.N.A. clinical and informational me to attacks more individuals to the in • Working with and attending Lea Age workshops specific to the C.N. shortage. The DON or designee will audit compliance with staffing through us resident interviews, monthly resider	ats, ng two has e a ose we hips d of lass; uctors aching ditation eaching ditation an Red ern MN eetings ndustry. ading A.	
	An undated nursing indicated R15 was When interviewed of	assistant care sheet to be bathed twice a week. on 3/27/18, at 2:19 p.m. R15 erns over not having enough			council meetings and family council meetings. The DON or designee w interview three residents per week weeks then monthly x3 months to e	l /ill x4	

Facility ID: 00049

		AND HUMAN SERVICES				FORM	05/17/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245491	B. WING			03/2	29/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	TANA MERCY CARE C	ENTER			10 SOUTH KENWOOD AVENUE IOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	staff available. R15 to an hour for assis times staff will come him they will be bac comes back and he R15 stated this was Point of Care Histor missed 16 of the tw R17's quarterly MD was cognitively inta staff assistance for interviewed on 3/27 "They need more p on to say that she s hour for assistance makes her uncomfor when she has to wa R38's significant ch indicated R38 had s did not refuse cares urine, and required bathing. R38's care staff to assist with b assistant workshee assisted with bathir interviewed on 3/26 she does not feel th to meet her needs. she received a bath enough, and certain concerns with havin brief for up to 15 m assist her in cleanin of Care History Rep	stated he often had to wait up tance to get out of bed, and at e in, turn off his light and tell ck in 10 minutes, but no one e has to turn on his light again. s frustrating for him. R15's ry Report identified he had vice weekly scheduled baths. S dated 1/5/18, indicated she loct, and required extensive most ADLs. When 7/18, at 12:21 p.m. R17 stated, eople working here." R17 went cometimes has to wait over an to get up in the morning, this portable and her body hurts	F 7	725	compliance with sufficient staffing. Corrected by: 5/4/2018		

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		AND HUMAN SERVICES				FORM	05/17/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245491	B. WING			03/2	29/2018
NAME OF	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA MERCY CARE C	ENTER			10 SOUTH KENWOOD AVENUE IOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	R56's quarterly MD was cognitively inta required physical he care plan dated 5/1 with bathing twice a Mondays. An unda worksheet directed Wednesdays, with a When interviewed of stated they are "Shi bath days wills will of R56 stated baths do missed, and this wa Point of Care Histor missed 10 of the tw January 1, 2018. R60's annual MDS had severe cognitive cares and required bathing. R60's care extensive assistant An undated nursing staff to bath R60 or interviewed on 3/27 the staff is really, "So on Tuesday, then th hair after breakfast aide if someone car Tuesday and no ba they did not have an R60 stated she doe doesn't get a bath a likes to get her hair History Report indic baths since Januar without a bath betw	S dated 3/5/18, indicated she ct, did not refuse cares and elp in part of bathing. R38's 3/15, directed staff to assist a week on Fridays and ted nursing assistant staff to assist with bathing on an extra bath on Saturdays. on 3/26/18, at 11:22 a.m. R56 ort of help for aides, some come and go without a bath." o not get, "Made up," if as distressing to her. R56's ry report indicated she had rice weekly baths since dated 3/2/18, included R60 re impairment, did not refuse total staff assistance for e plan directed staff to provide ce with bathing on Tuesdays. J assistant worksheet directed	F	725			

Facility ID: 00049

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		AND HUMAN SERVICES				FORM	: 05/17/2018 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245491	B. WING			03/	29/2018
NAME OF F	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA MERCY CARE C	ENTER			10 SOUTH KENWOOD AVENUE IOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 725	Continued From pa	ige 43	F 7	25			
	assistance from sta interviewed on 3/2/ she has had to wait	v intact, and required extensive aff for most ADLs. When 18, at 1:09 p.m. R62 stated t on the bed pan for up to 20 ng the call light on for staff to					
	interviewed on 3/26 she has trouble get bathroom timely, or	ently admitted, and when 6/18, at 2:24 p.m. she stated tting assistance to the n one occasion she waited an 5 stated, "They don't have					
	dated February 28, baths being missed	ent Council Meeting Notes 2018 noted a concern over d due to staff shortages. No rted to the residents.					
	nursing assistant (N short staffed, the ba the floor doing nurs baths do not get do	on 3/27/18, at 3:47 p.m. NA)-B stated they are often ath aide gets pulled to work on se aide duties, and then the one. The nursing assistants are a, and the baths get missed.					
	stated bath aide ge	on 3/27/18, at 3:54 p.m. NA-C ats pulled, "A lot," and they will as done the next day, but it appen.					
	stated they do not h afternoon shift, and	on 3/27/18, on 3:59 p.m. NA-A nave a bath aide on the I they are unable to get baths get done on the day shift.					
		on 3/27/19, at 4:02 p.m. NA-D t always get done, and they catch up on them.					

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		AND HUMAN SERVICES				FORM	05/17/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245491	B. WING _			03/:	29/2018
NAME OF F	PROVIDER OR SUPPLIER	•		STF	REET ADDRESS, CITY, STATE, ZIP CODE	-	
AUGUST	ANA MERCY CARE C	ENTER			0 SOUTH KENWOOD AVENUE DOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	:	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	Continued From pa	ıge 44	F 72	25			
	stated they can usu	on 3/28/18, at 7:05 a.m. NA-G ually get the work done but it is is do not always get done.					
		on 3/28/18, at 7:57 a.m. NA-H e had called in for the day. t done that day.					
	stated she had offe	on 3/28/18, at 9:22 a.m. NA-I ared to do baths today for her lunteers, "They will get done					
	administrator stated baths not always ge addressing the issu and assurance (QA nursing (DON) state they try to get an ex have a bath aide, or	on 3/28/18, at 9:48 a.m. the d the facility was aware of etting done, they are currently ue in their quality assessment (A) committee. The director of ed they are still working on it, ktra person in if they do not r will try and get someone to get the baths done.					
	stated she is often t gets pulled very free get baths done and NA-F became weep good job," because	on 3/29/18, at 7:39 a.m. NA-F the assigned bath aide but quently. NA-F stated she can't I meet everyone's other needs. py and stated they, "Can't do a there is not enough nursing le all the cares timely.					
	licensed practical n	on 3/29/18, at 10:40 a.m. ourse (LPN)-A stated she is e nurse aides with bathing as self.					
		on 3/29/18, at 7:56 a.m. NA-K bath aide at least weekly.					

If continuation sheet Page 45 of 50

		AND HUMAN SERVICES				FORM	05/17/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATE	E SURVEY IPLETED
		245491	B. WING			03/:	29/2018
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
AUGUST	ANA MERCY CARE C	ENTER			IO SOUTH KENWOOD AVENUE OOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	Continued From pa	age 45	F 7	25			
		is no way to catch up on them, e is asked to stay late to catch en.					
	registered nurse (R nursing assistant ca aide from doing bat happens the nursin do all the baths. Th the baths have not Occasionally, a nur bath had not been of this to the afternoor do it. This is not fol resident actually ref When interviewed of human resource din	sing assistant will report a completed, and she reports n shift so that they can try and llowed up on to see if the					
	working with a recru local colleges and r They have a nurse themselves offering retain more nursing	uiting company as well as the nurse aide training program. aide training program g on-site clinical's to obtain and g assistants. HR stated there se aides in the market place.					
	who works mainly t just her and one nu 300 and 200 wing, call lights timely and	on 3/29/18, at 7:39 a.m. NA-E the night shift, stated there is urse on at night for both the and she is unable to answer d if residents want up early, lp them, they have to wait until n for the day.					
	nursing staff sched assistants call in, th	on 3/29/18, at 7:47 a.m. the uler (NS)-A stated if nursing ney do attempt to cover the n't, "Pull" the bath aide, if					

Facility ID: 00049

If continuation sheet Page 46 of 50

		AND HUMAN SERVICES				FORM	05/17/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245491	B. WING			03/:	29/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
AUGUST	ANA MERCY CARE C	ENTER			10 SOUTH KENWOOD AVENUE IOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	unable to replace sibaths to ensure the openings for nursin with a recruiting age have hired more nursin still in training and estated she does not Health Care Center there was staff who be replaced. The Facility Wide R 11/2017, identified a ensure sufficient staneeds of residents addressed a need f assistants) at 80 ho	age 46 taff would need to reschedule by got done. They have a lot of ag assistants, and are working ency to secure more. They arsing assistants, but they are expect it to get better. NS-A t update the Augustana Mercy r Report on Nursing Staff when to called in sick and could not Resource Assessment dated an approach to staffing to aff were available to meet the at any given time. The plan for 80 direct care staff (nursing burs on the day shift, 60 hours inft and 24 hours on the night	F 7	725			
F 770 SS=D	of Nursing Staff from March 28, 2018, ide scheduled for betwee shift, before call-ins 80 hour need on the times. The report at aides scheduled for the evening shift, or hour need twice. Laboratory Services CFR(s): 483.50(a)(§483.50(a) Laborat §483.50(a)(1) The laboratory services	1)(i) fory Services. facility must provide or obtain to meet the needs of its ity is responsible for the quality	F 7	770			5/4/18

Facility ID: 00049

If continuation sheet Page 47 of 50

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE	0938-039
ND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	СОМ	PLETED
		245491	B. WING		03/2	29/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA MERCY CARE C	ENTER		710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETIC DATE
F 770	 (i) If the facility proviservices, the service requirements for la of this chapter. This REQUIREMED by: Based on interview facility failed to ensilaboratory monitoring residents (R56) revised medications. Findings include: R56's Face Sheet provide the blood of the blood of	vides its own laboratory ses must meet the applicable boratories specified in part 493 NT is not met as evidenced v and document review, the ure physician ordered ng was completed for 1 of 5 riewed for unnecessary orinted 3/29/18, identified R56 I anemia (a lack of healthy red morbid obesity and ndition with high levels of fat od). signed Physician Order Report tified a laboratory monitoring est: (Lipids)," to be completed to A start date for this ng order was listed as 12/3/14. ort identified R56 currently edications which included: spastic agent) 5 milligrams day for multiple sclerosis; that high cholesterol) 20 mg e for hyperlipidemia; de (a diuretic) 25 mg once a oressure; and sychotic medication) 2.5 mg	F 770	It is the policy of Augustana Care Lake Health and Rehabilitation to laboratory services that meet the the resident population. The "lipi for R56 was ordered and results reviewed by the resident's physic 4/24/18 with no noted changes to of care. The Augustana policy er ordering was reviewed and updat LN and health information emplo be re-educated on the lab orderir procedure. All residents in the bu will have their lab orders reviewer compliance. DON or Designee w two resident records per week x4 then monthly x 3 months to ensu compliance. Results of all audits reviewed by the QAPI committee Corrected by: 5/4/2018.	provide needs of d panel" were ian on the plan titled lab ed. All yees will g ilding d for rill audit weeks re will be	

If continuation sheet Page 48 of 50

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE					FORM	05/17/2018 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DAT	E SURVEY IPLETED
	245491	B. WING			03/	29/2018
NAME OF PROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
AUGUSTANA MERCY CARE C	ENTER			710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
 blood lipids, such as completed in Octobe by R56's physician. When interviewed or registered nurse (RI R56's medical record laboratory itself, how panel completed in laboratory test was long-standing order was just missed." Fillaboratory testing sharesidents to see if m continued or adjusted During interview on consulting pharmac reviewed R56's medication for the been completed. CF ordered a laboratory would expect it to be [staff] identified it." A facility provided M (MMR) policy dated would review each monthly basis for a laboratory results, medication therapy by prescribers/staff 	n for abnormalities in the s cholesterol) had been er 2017, as had been ordered	F 7	770			

Facility ID: 00049

If continuation sheet Page 49 of 50

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				FORM APPROVED MB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245491	B. WING		03/29/2018
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
			710 SOUTH KENWOOD AVENUE	
AUGUSTANA MERCY CARE C	ENTER		MOOSE LAKE, MN 55767	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTION
F 770 Continued From par physician.	ge 49	F 77(

Facility ID: 00049

PRINTED: 05/17/2018

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	CONSTRUCTION 1 - MAIN BUILDING 01		TE SURVEY
		245404	B. WING			100/0040
	PROVIDER OR SUPPLIER	245491		REET ADDRESS, CITY, STATE, ZIP CODI		/28/2018
	NOVIDER OR SOFFLIER			0 SOUTH KENWOOD AVENUE	-	
UGUST	ANA MERCY CARE C	ENTER	M	OOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETI DATE
K 000	INITIAL COMMENT	ſS	K 000			
	FIRE SAFETY					
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.				
	ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.				
	Minnesota Departm Fire Marshal Divisio Augustana Mercy C compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National I	Survey was conducted by the nent of Public Safety, State on. At the time of this survey, Care Center was found not in a requirements for participation aid at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association 01, Life Safety Code (LSC), 9 Health Care.			_	
		E AN EPOC, A PAPER COPY CORRECTION IS NOT		EPOC		
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K	R THE FIRE SAFETY				

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.

		AND HUMAN SERVICES			FORM	05/01/2018 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		E SURVEY IPLETED
		245491	B. WING		03/	28/2018
	PROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CC 710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 000	Continued From pa	ge 1	K 00	00		
	HEALTH CARE FIR STATE FIRE MARS 445 MINNESOTA S ST. PAUL, MN 551	SHAL DIVISION STREET, SUITE 145				
	By e-mail to both: Marian.Whitney@s and Angela.Kappenmar					
		RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:				
	1. A description of v to correct the defici	what has been, or will be, done ency.				
	2. The actual, or pr	oposed, completion date.				
	-	r title of the person rection and monitoring to ence of the deficiency				
	building with small building was constru- constructed in 1968 construction). A sir nursing home and i To the south a sing living facility also ac hour construction w	Care Center is a 1-story partial basement. The original ucted in 1964 and additions 3 and 1977, all of Type II(111 ngle story hospital adjoins the s separated by a 4 hour wall. le story type V(111) assisted djoins and is separated by 4 <i>v</i> ith a 3 hour rated, self closing e nursing home was inspected				
	The building is fully	sprinkler protected. The				

Event ID: MUKC21

Facility ID: 00049

If continuation sheet Page 2 of 4

	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA				0938-039
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING		(X3) DATE SURVEY COMPLETED		
				03/	28/2018	
NAME OF	PROVIDER OR SUPPLIEF	1 2	· · · · · ·	STREET ADDRESS, CITY, STATE, ZIP C	ODE	
AUGUST	ANA MERCY CARE	CENTER		710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 000	Continued From p	-	КO	00		
	smoke detection in open to the corride	blete fire alarm system with the corridors and spaces or, that is monitored for artment notification.				
		icensed capacity 72 beds and 4 at the time of the survey.				
	NOT MET.	at 42 CFR Subpart 483.70(a) is uilding System Categories	К9	01		4/27/18
	Building systems a 1 through 4 require Categories are de					
	This REQUIREME	NT is not met as evidenced				
	Based on observa facility has failed to current facility Risk with the NFPA 99 2012 edition section could affect 72 of	ation and staff interview, the o provide a complete and k Assessment in accordance 'Health Care Facilities Code" on 4.1. This deficient practice 72 residents, as well as an ober of staff, and visitors.		It is the policy of Augustana to complete a formal and d risk assessment for building equipment performed by a person. Corrective Action Description The facility completed an ea specific risk assessment to	ocumented g systems, and qualified staff on: quipment	
	Findings include:			level of risk determined for equipment in the facility. The and Gas Equipment Assess	all patient care ne Electrical	

Event ID: MUKC21

Facility ID: 00049

If continuation sheet Page 3 of 4

		AND HUMAN SERVICES			FORM	: 05/01/2018 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DAT	E SURVEY IPLETED
		245491	B. WING		03/	28/2018
	PROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZI 710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
K 901	On facility tour betw on 03/28/2018, dur and an interview wi it was revealed that document did not a and equipment ider the NFPA 99 "Healt edition.	veen 10:30 a.m. to 1:30 p.m. ing the documentation review ith the Maintenance Supervisor t the facility's risk assessment account for all of the systems ntified in chapter 10 and 11 of th Care Facilities Code" 2012	K 90	be reviewed on an annua updated at the time of an addition of resident care The current assessment attached to this ePOC. (DATE Corrected: 4/27/1 Completed by: Jason Joh Director of Maintenance	y change or equipment. has been (8)	
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: MUKC2	21	Facility ID: 00049	If continuation she	eet Page 4 of



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered April 17, 2018

Ms. Tara Peterson, Administrator Augustana Mercy Care Center 710 South Kenwood Avenue Moose Lake, MN 55767

Re: State Nursing Home Licensing Orders - Project Numbers S5491027, H5491019, H5491020

Dear Ms. Peterson:

The above facility was surveyed on March 26, 2018 through March 29, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

Augustana Mercy Care Center April 17, 2018 Page 2

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Teresa Ament, Unit Supervisor, at (218) 302-6151 or teresa.ament@state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

Montylan

Michaelyn Bruer, Enforcement Specialist Minnesota Department of Health Health Regulation Division Program Assurance Unit phone 651-201-4117 fax 651-215-9697 email: <u>michaelyn.bruer@state.mn.us</u>

cc: Licensing and Certification File

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMP	SURVEY LETED
		00049	B. WING		03/2	9/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
AUGUST	ANA MERCY CARE C	ENTER	H KENWOO AKE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm The State delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
_ABORATOR	epartment of Health Y DIRECTOR'S OR PROVID ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 04/25/18

Electronically Signed

If continuation sheet 1 of 46

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 000049		A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/29/2018		
		B. WING				
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
UGUST	ANA MERCY CARE C	:FNTER	OUTH KENWOO E LAKE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	ge 1	2 000			
	you electronically. is necessary for Sta enter the word "corr text. You must then State licensure pro- completion date, th	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available f indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the ment of Health.	on			
	surveyors of this De above provider and orders are issued. electronic plan of co	, through March 29, 2018, epartment's staff visited the the following correction Please indicate in your prrection that you have ers, and identify the date wh ted.	en			
	the State Licensing federal software. Ta	nent of Health is documentin Correction Orders using ag numbers have been ota state statutes/rules for	g			
	column entitled "ID statute/rule out of c "Summary Stateme and replaces the "T correction order. Th findings which are i after the statement evidence by." Follow	umber appears in the far lef Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the his column also includes the n violation of the state statut , "This Rule is not met as wing the surveyors findings Method of Correction and rrection.				
2 800	MN Rule 4658.0510 Staffing requiremer) Subp. 1 Nursing Personne hts	l; 2 800			5/4/18

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00049	B. WING		03/2	9/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		710 SOUT				
AUGUSI	ANA MERCY CARE C	MOOSE L	AKE, MN 5	5767		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 2	2 800			
	home must have or number of qualified registered nurses, I nursing assistants to residents at all nurse in all buildings if mo- involved. This inclu- and vacation replace This MN Requireme- by: Based on observati review, the facility fa- enough staff availal R5, R12, R13, R15 and R265) intervier assistance they nee- was often not timely NA-C, NA-A, NA-D, LPN-A, NA-K, RN-A	ent is not met as evidenced on, interview, and document ailed to ensure there was ble for 11 of 18 residents (R3, , R17, R38, R56, R60, R62, wed who did not receive the eded, or felt the assistance y. In addition, 12 of 16 (NA-B, , NA-G, NA-H, NA-I, NA-F, A, and NA-E) staff members t not having enough staff to		Corrected		
	Findings include:					
	12/18/17, indicated not refuse cares, re with toileting, and w staff to bathe. Whe 3:05 p.m. R3 stated staff." R3 went on to get up in the mornin this creates a probl bathroom and can't incontinent which is	imum Data Set (MDS) dated R3 was cognitively intact, did equired extensive assistance vas totally dependent upon two en interviewed on 3/26/18, at d, "They are always short of o say she has had to wait to ng until more people arrive, em when she has to go to the hold it. She then becomes a upsetting to her. R3 also of enough staff to make sure ery week.				

MUKC11

STATEMEN	It of Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
00049		B. WING		03/	29/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
AUGUST	ANA MERCY CARE (CENTER	TH KENWOOI AKE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From pa	are 3	2 800	DEFICIENC	Y)	
2 000		ige 5	2 000			
	had missed four we	History report indicated she eekly baths since January 1, 21 days without a bath id 1/26/18.				
	R5's quarterly MDS dated 12/19/17, included R5 was cognitively intact, did not reject cares, required extensive assistance from staff for toileting and total staff assistance with bathing. When interviewed on 3/26/18, at 11:48 a.m. R5 stated there was not enough staff to meet her needs timely. She stated in the morning when she wakes up she needs to go to use the commode right away, it often takes 15 to 20 minutes for someone to come, and by then holding in the urine is painful. Once she gets to the commode she then has trouble urinating. R5 also had a concern about not getting a weekly bath, which she stated she typically does not like bathing, but needs to due to skin concerns under breasts and abdominal folds. R5's Point of Care History report indicated she had only received a bath once each month since January 1, 2018. R5 had refused two of the baths which were scheduled weekly for her.					
	was cognitively inta required one perso ambulation and bat 1/1/18, indicated st assist with a showe interviewed on 3/27	dated 12/29/17, indicated she act, did not reject cares, and in physical assistance with thing. R12's care plan dated aff were to ambulate daily, and er twice a week. When 7/18, at 9:55 a.m. R12 stated stroesophageal reflux disease)				
	needs medication of coming up. Staff d is really uncomforta	her call light at night if she due to, "Stomach stuff," o not come right away and this able for her. R12 expressed as not being assisted with				

MUKC11

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00049	B. WING		03/29/2018		
	PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE. ZIP CODE	03/	03/29/2010	
AUGUST	TANA MERCY CARE (CENTER 710 SOU	TH KENWOOI AKE, MN 55	DAVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PL/ (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECT/ REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCE		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE	
2 800	Continued From pa	age 4	2 800				
	needs staff with he upsetting to her. R Report indicated sh a week baths since R13's annual MDS was cognitively inta was totally depended care plan dated 11/ extensive assistant assist for dressing, praise him for parti undated nursing as R13 should be ass When interviewed stated he is suppose but there is not end if there is a bath aid giving baths much R13 stated he knew this happened quite of when he had or scheduled bath. In been, "Really short only having one nu on the wing, usually that is not even end that he is capable of staff do it for him as R13's Point of Care missed 13 twice a 2018. R15's quarterly MD had moderate cogn cares, required ext activities of daily liv dependent upon st	lay, she is at risk for falling, so r. R12 stated this was 5's Point of Care History he had missed 12 of the twice a January 1, 2018. dated 12/30/17, indicated he fact, did not reject cares, and ent upon staff to bathe. R13's /4/15, indicated he required ce for bathing and extensive staff were to encourage and cipation in dressing. An esistant worksheet indicated isted with a bath twice a week. on 3/26/18, at 1:10 p.m. R13 sed to get a bath twice a week, ough staff on. R13 stated even de on, they get pulled from of the time to do other things. w he missed a bath last week, e often, but had not kept track had not received the addition, R13 stated they have to f staff," lately sometimes rse aide for the 22 residents y have two nurse aides and ough. R13's other concern was of dressing self with set up, but s they are in, "Such a hurry." e History showed he had week baths since January 1, 0S dated 1/2/18, indicated R15 nitive impairment, did not reject ensive assistance for most <i>ring</i> (ADLs) and was totally aff for bathing. R15's care to provide two baths per week.					

STATE FORM

MUKC11

If continuation sheet 5 of 46

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00040	B. WING			
		00049			03/29/2018	
AME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
UGUST	TANA MERCY CARE	CENTER	TH KENWOOD LAKE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
				DEFICIENC	()	
2 800	Continued From pa	age 5	2 800			
	indicated R15 was When interviewed stated he had cond staff available. R15 to an hour for assis times staff will com him they will be bar comes back and he R15 stated this wa Point of Care Histo missed 16 of the tw R17's quarterly ME was cognitively inta staff assistance for interviewed on 3/27 "They need more p on to say that she hour for assistance	g assistant care sheet to be bathed twice a week. on 3/27/18, at 2:19 p.m. R15 cerns over not having enough 5 stated he often had to wait up stance to get out of bed, and at he in, turn off his light and tell ck in 10 minutes, but no one has to turn on his light again. s frustrating for him. R15's bry Report identified he had vice weekly scheduled baths. OS dated 1/5/18, indicated she act, and required extensive most ADLs. When 7/18, at 12:21 p.m. R17 stated, beople working here." R17 wen sometimes has to wait over an e to get up in the morning, this fortable and her body hurts ait so long.	t			
	indicated R38 had did not refuse care urine, and required bathing. R38's car staff to assist with assistant workshee assisted with bathin interviewed on 3/20 she does not feel ti to meet her needs. she received a bath enough, and certai concerns with havi brief for up to 15 m assist her in cleani	hange MDS dated 2/4/18, severe cognitive impairment, s, was always incontinent of total assistance from staff for re plan dated 1/17/18, directed bathing. An undated nursing et indicated R38 should be ng on Wednesdays. When 6/18, at 1:59 p.m. R38 stated here is enough staff available . R38 did not know how often h, but didn't think it was often nly not weekly. R38 also had ng to sit in a wet incontinent inutes before staff would ng and a dry pad. R38's Point port indicated she had missed				

	<u>ota Department of He</u> NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION		E SURVEY PLETED	
		00049	B. WING		03/29/2018		
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST I TH KENWOOE				
AUGUST	ANA MERCY CARE C	SENTER	LAKE, MN 557				
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCE		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 800	Continued From pa	ige 6	2 800				
	five scheduled wee 2018.	kly baths since January 1,					
	was cognitively intact, did not refuse cares and required physical help in part of bathing. R38's care plan dated 5/13/15, directed staff to assist with bathing twice a week on Fridays and Mondays. An undated nursing assistant worksheet directed staff to assist with bathing on Wednesdays, with an extra bath on Saturdays. When interviewed on 3/26/18, at 11:22 a.m. R56 stated they are "Short of help for aides, some bath days wills will come and go without a bath." R56 stated baths do not get, "Made up," if missed, and this was distressing to her. R56's Point of Care History report indicated she had missed 10 of the twice weekly baths since January 1, 2018. R60's annual MDS dated 3/2/18, included R60 had severe cognitive impairment, did not refuse						
	bathing. R60's care extensive assistance An undated nursing staff to bath R60 or interviewed on 3/27 the staff is really, "S on Tuesday, then th hair after breakfast	total staff assistance for e plan directed staff to provide ce with bathing on Tuesdays. g assistant worksheet directed n Tuesdays. When 7/18, at 11:03 a.m. R60 stated Short," she used to get a bath ney would come in and set her . R60 stated they pull the bath lls in sick. R60 stated today is	1				
	Tuesday and no ba they did not have a R60 stated she doe doesn't get a bath a likes to get her hair History Report indic	th yet, she had just found out nyone to give baths today. es not feel good when she at least every week, and really set. R60's Point of Care cated she had missed four y 1, 2018, once going 21 days					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00049	B. WING		03/29/2018		
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		00/20/2010	
	ANA MERCY CARE	710 SOU					
-00001		MOOSE	LAKE, MN 557	767			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 800	Continued From pa	age 7	2 800				
: ; ; ;	R62's admission MDS dated 3/7/18, indicated she was cognitively intact, and required extensive assistance from staff for most ADLs. When interviewed on 3/2/18, at 1:09 p.m. R62 stated she has had to wait on the bed pan for up to 20 minutes after placing the call light on for staff to remove it.						
	interviewed on 3/26 she has trouble ge bathroom timely, o	cently admitted, and when 6/18, at 2:24 p.m. she stated tting assistance to the n one occasion she waited an 5 stated, "They don't have					
	dated February 28 baths being missed	lent Council Meeting Notes , 2018 noted a concern over d due to staff shortages. No orted to the residents.					
	nursing assistant (short staffed, the b the floor doing nurs baths do not get do	on 3/27/18, at 3:47 p.m. NA)-B stated they are often wath aide gets pulled to work on se aide duties, and then the one. The nursing assistants are n, and the baths get missed.					
	stated bath aide ge	on 3/27/18, at 3:54 p.m. NA-C ets pulled, "A lot," and they will ns done the next day, but it appen.					
	stated they do not afternoon shift, and	on 3/27/18, on 3:59 p.m. NA-A have a bath aide on the d they are unable to get baths t get done on the day shift.					
		on 3/27/19, at 4:02 p.m. NA-D t always get done, and they					

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00049	B. WING		03/	03/29/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
AUGUST	ANA MERCY CARE	CENTER	TH KENWOOI				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE	
2 800	Continued From pa	age 8	2 800				
	don't have time to a	catch up on them.					
	When interviewed on 3/28/18, at 7:05 a.m. NA-G stated they can usually get the work done but it is a struggle, the baths do not always get done.						
	When interviewed on 3/28/18, at 7:57 a.m. NA-H stated the bath aide had called in for the day. Baths would not get done that day.						
	stated she had offe	on 3/28/18, at 9:22 a.m. NA-I ered to do baths today for her lunteers, "They will get done					
	administrator state baths not always g addressing the issu and assurance (QA nursing (DON) stat they try to get an ex have a bath aide, c	on 3/28/18, at 9:48 a.m. the d the facility was aware of etting done, they are currently ue in their quality assessment AA) committee. The director of ted they are still working on it, extra person in if they do not or will try and get someone to get the baths done.	F				
	stated she is often gets pulled very fre get baths done and NA-F became wee good job," because	on 3/29/18, at 7:39 a.m. NA-F the assigned bath aide but equently. NA-F stated she can't d meet everyone's other needs py and stated they, "Can't do a e there is not enough nursing de all the cares timely.					
	licensed practical r	on 3/29/18, at 10:40 a.m. hurse (LPN)-A stated she is e nurse aides with bathing as rself.					
		on 3/29/18, at 7:56 a.m. NA-K bath aide at least weekly.					

STATE FORM

MUKC11

If continuation sheet 9 of 46

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00049	B. WING		03/29/2018		
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	ADDRESS, CITY, STATE, ZIP CODE				
AUGUST	ANA MERCY CARE (CENTER	TH KENWOOI LAKE, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 800	Continued From pa	age 9	2 800				
		is no way to catch up on them, e is asked to stay late to catch en.					
	registered nurse (F nursing assistant c aide from doing ba happens the nursin do all the baths. The baths have not Occasionally, a nur bath had not been this to the afternoo	rsing assistant will report a completed, and she reports n shift so that they can try and illowed up on to see if the					
	human resource di aware of nursing as working with a recr local colleges and r They have a nurse themselves offering retain more nursing	on 3/29/18, at 8:41 a.m. the rector (HR) stated they are ssistant shortages and are uiting company as well as the nurse aide training program. aide training program g on-site clinical's to obtain and g assistants. HR stated there rse aides in the market place.					
	who works mainly t just her and one nu 300 and 200 wing, call lights timely an	on 3/29/18, at 7:39 a.m. NA-E the night shift, stated there is urse on at night for both the and she is unable to answer d if residents want up early, lp them, they have to wait until n for the day.					
	nursing staff sched assistants call in, th shift. They shouldr	on 3/29/18, at 7:47 a.m. the luler (NS)-A stated if nursing ney do attempt to cover the n't, "Pull" the bath aide, if staff would need to reschedule					

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	00049	B. WING		03/	03/29/2018	
PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
ANA MERCY CARE O	SENTER					
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
Continued From pa	age 10	2 800				
openings for nursin with a recruiting ag have hired more nu still in training and o stated she does no Health Care Center there was staff who be replaced. The Facility Wide F	ig assistants, and are working ency to secure more. They ursing assistants, but they are expect it to get better. NS-A it update the Augustana Mercy r Report on Nursing Staff wher o called in sick and could not Resource Assessment dated					
ensure sufficient st needs of residents addressed a need assistants) at 80 ho	aff were available to meet the at any given time. The plan for 80 direct care staff (nursing burs on the day shift, 60 hours					
of Nursing Staff fro March 28, 2018, id scheduled for betw shift, before call-ins 80 hour need on th times. The report a aides scheduled fo	m February 28, 2018, to entified they had nurse aides een 52 and 80 hours each day s, only meeting the identified e Resource Assessment four lso identified they had nurse r between 42 and 60 hours on	,				
The administrator of review, and /or revi ensure appropriate available to care fo administrator or de	or designee could develop, se policies and procedures to nursing staffing levels were r the residents. The signee could develop					
	OF CORRECTION PROVIDER OR SUPPLIER ANA MERCY CARE C SUMMARY STA (EACH DEFICIENC) REGULATORY OR L Continued From particular baths to ensure the openings for nursing with a recruiting ag have hired more nursing with a recruiting and stated she does not Health Care Center there was staff who be replaced. The Facility Wide F 11/2017, identified ensure sufficient staneeds of residents addressed a need assistants) at 80 ho on the afternoon standiff. The Augustana Me of Nursing Staff fro March 28, 2018, id scheduled for betwas shift. The Augustana Me of Nursing Staff fro March 28, 2018, id scheduled for betwas shift, before call-ins 80 hour need on that times. The report and aides scheduled for the evening shift, or hour need twice. SUGGESTED MET The administrator or review, and /or revie available to care for administrator or de monitoring systems	OF CORRECTION IDENTIFICATION NUMBER: 00049 00049 PROVIDER OR SUPPLIER STREET AI ANA MERCY CARE CENTER 710 SOU MOOSE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 baths to ensure they got done. They have a lot of openings for nursing assistants, and are working with a recruiting agency to secure more. They have hired more nursing assistants, but they are still in training and expect it to get better. NS-A stated she does not update the Augustana Mercy Health Care Center Report on Nursing Staff wher there was staff who called in sick and could not be replaced. The Facility Wide Resource Assessment dated 11/2017, identified an approach to staffing to ensure sufficient staff were available to meet the needs of residents at any given time. The plan addressed a need for 80 direct care staff (nursing assistants) at 80 hours on the day shift, 60 hours on the afternoon shift and 24 hours on the night shift. The Augustana Mercy Health Care Center Report of Nursing Staff from February 28, 2018, to March 28, 2018, identified they had nurse aides scheduled for between 52 and 80 hours each day shift, before call-ins, only meeting the identified 80 hour need on the Resource Assessment four times. The report also identified they had nurse aides scheduled for between 42 and 60 hours on the evening shift, only meeting the identified 60 hour need twice. SUGGESTED METHODS OF CORRECTION: The administrator or designee could develop, review, and /or revise policies and procedures to ensure appropriate nursing staffing levels were available to care for the residents. Th	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00049 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST ANA MERCY CARE CENTER 710 SOUTH KENWOOD MOOSE LAKE, MN 55' SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 10 2 800 baths to ensure they got done. They have a lot of openings for nursing assistants, and are working with a recruiting agency to secure more. They have hired more nursing assistants, but they are still in training and expect it to get better. NS-A stated she does not update the Augustana Mercy Health Care Center Report on Nursing Staff when there was staff who called in sick and could not be replaced. The Facility Wide Resource Assessment dated 11/2017, identified an approach to staffing to ensure sufficient staft were available to meet the needs of residents at any given time. 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WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ANA MERCY CARE CENTER T10 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767 SUMMARY STATEMENT OF DEFICIENCIES ID PREFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX PROVIDER'S PLAN OF OF (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D Prefix TAG PROVIDER'S PLAN OF OF (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D Prefix TAG CROSS-REFERENCED TO T DEFICIENCY CROSS-REFERENCED TO T DEFICIENCY Continued From page 10 2 800 2 800 EACH ORRECTIVE ACT REGULATORY OR LSC IDENTIFYING INFORMATION) Daths to ensure they got done. They have a lot of openings for nursing assistants, but they are still in training and expect it to get better. NS-A stated she does not update the Augustana Mercy Health Care Center Report on Nursing Staff when there was staff who called in sick and could not be replaced. The Facility Wide Resource Assessment dated 11/2017, identified an approach to staffing to ensure approach to staffing to ensure approach to staffing to nursing Staff from February 28, 2018, to March 28, 2018, identified they had nurse aides scheduled for between 52 and 80 hours each day shift, before call-ins, only meeting the identified 60 hour need wice. SUGGESTED METHODS OF CORRECTION: The administrator or designee could deve	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: COM 00049 B. WING 037 PROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE 713 SOUTH KENWOOD AVENUE ANA MERCY CARE CENTER 710 SOUTH KENWOOD AVENUE DPOVIDER'S PLAN OF CORRECTION NUST BE PRECEDED BY FULL ID REGULATORY ON LGC IDENTIFYING INFORMATION) ID PRETRY CROSS-REFRENCED TO THE APPROPRIATE Continued From page 10 2 800 2 800 CROSS-REFRENCED TO THE APPROPRIATE DEFICENCY Continued From page 10 2 800 2 800 CROSS-REFRENCED TO THE APPROPRIATE DEFICENCY Continued From page 10 2 800 2 800 CROSS-REFRENCED TO THE APPROPRIATE DEFICENCY Continued From page 10 2 800 2 800 CROSS-REFRENCED TO THE APPROPRIATE DEFICENCY Continued From page 10 2 800 CROSS-REFRENCED TO THE APPROPRIATE DEFICENCY DEFICENCY Continued From page 10 2 800 CROSS-REFRENCED TO THE APPROPRIATE DEFICENCY Continued From page 10 CROSS-REFRENCED TO THE APPROPRIATE DEFICENCY DEFICENCY Continued From page 10 CROSS-REFRENCED TO THE APPROPRIATE DEFICENCY DEFICE	

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMP	SURVEY LETED
		00049	B. WING		03/29/2	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AUGUSTANA MERCY CARE CENTER		TH KENWOC AKE, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 800	Continued From pa	ge 11	2 800			
	(21) days.					
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General		2 830			5/4/18
	Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.					
	by: Based on observati review, the facility fa interventions from of prevent skin break 1 of 5 residents (R2 who had limited ran Findings include: R214's 14-day Mini 3/5/18, identified R2 impairment, and red	ent is not met as evidenced on, interview and document ailed to provide assessed occupational therapy (OT) to down in a contracted hand for 214) reviewed for mobility and age of motion (ROM). mum Data Set (MDS) dated 214 had severe cognitive quired extensive assistance ansfers and personal hygiene.		Corrected.		
	Further, R214 had a	a functional limitation in ROM skin lesions, burns or other				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00049	B. WING		03/29/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
AUGUS	TANA MERCY CARE O	FNTFR	TH KENWOOE LAKE, MN 557			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
2 830	R214's Therapy to dated 3/9/18, identi occupational therap [R214's] [left] hand, to [left] hand." The occupational therap care plan revised 3, intervention direction hand daily, skin car During observation was laying in bed in contracted left hand muscle) with the fin her palm, causing t fist. There was no la left hand. During subsequent 10:19 a.m., 3/27/18 7:16 a.m. R214 was any lambs wool insi directed by the OT On 3/28/18, at 7:55 and NA-B entered F morning cares. R2 assisted to sit in he mechanical lift. Nei applied lambs wool these cares, nor wh R214's left hand wa visible cuts, lesions When interviewed of stated she was not wool being used in	Nursing Communication sheet fied a directive from by (OT) for, "Lambs wool to daily skin care to be provided sheet was signed by bist (OT)-A. Further, R214's /28/18, identified an ng, "Apply lambs wool to left to be provided to left hand." on 3/26/18, at 3:54 p.m. R214 ther room. R214 had a visibly d (shortening and hardening of gers turned inward, towards he left hand to appear like a ambs wool visible in R214's observation(s) on 3/27/18, at s again observed to not have ide or on the left hand as recommendation. a.m. nursing assistant (NA)-A R214's room to provide 14 was washed, dressed, and r wheelchair using a ther of the NA staff provided or to R214's left hand during hen they were completed. as observed and lacked any				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00049	B. WING		03/29/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
AUGUST	ANA MERCY CARE O	:ENTER	TH KENWOOI LAKE, MN 55 [°]			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
2 830	During interview on stated she had nev used on R214's cor staff will provide he like a lamb, and sh hand which was no R214 should be try her left, contracted therapy recommen and ROM programs resident's closet do them when caring f NA-B and the surve closet door, and NA instructions posted lambs wool to R214 When interviewed of registered nurse (R provides nursing wi post-therapy discha- implemented by nu communication (da directed to insert la contracted left hand NA just brought a c were fearful R214 r was unable to answ been used in R214 directed by OT on 3	a 3/28/18, at 9:50 a.m. NA-B ber seen lambs wool being intracted left hand, however, in with a squeeze ball shaped e will often hold it in her other it contracted. NA-B stated ing to use the squeeze ball in hand. Further, NA-B explained dations for splints, devices, s would be placed inside a bor so staff could reference for a person. At 12:44 p.m. eyor observed R214's inside A-B verified there were no pertaining to the application of				
	and coordinated wi can have appropria During interview on stated R214 was up on the left hand due lambs wool should	oner so they could be clarified th therapy adding, "Then we the care for the resident." a 3/29/18, at 11:16 a.m. OT-A nable to use a palm protector e to the contracture. The have been placed in the left g the skin" and preventing skin				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED	
		00049	B. WING		03/	03/29/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
AUGUST	ANA MERCY CARE	CENTER	TH KENWOOD LAKE, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	age 14	2 830				
	with interventions p notify the departme "sooner than that ["always a risk of [fu skin breakdown. A facility policy on o therapies (PT / OT	explained if staff had concerns provided by OT, they should ent to have them addressed 19 days later]" as their was urther] decline" in ROM and coordination of care with) and/or contracture vas requested, however, none					
	The director of nur- develop and/or rev education for staff coordination/comm therapy services re resident care interv	THOD OF CORRECTION: sing (DON) or designee could iew policies and provide regarding nunication with occupational elated to implementation of <i>t</i> tions. The DON or designee lom audits to ensure					
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one					
2 895	MN Rule 4658.052 Motion	5 Subp. 2.B Rehab - Range of	2 895			5/4/18	
	that is directed tow through positioning implemented and r comprehensive res of nursing services	motion. A supportive program ard prevention of deformities and range of motion must be naintained. Based on the sident assessment, the director must coordinate the nursing care plan which					
		th a limited range of motion te treatment and services to					

Minnesota Department of Health						"THOVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMPI	
		00049	B. WING		03/2	9/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AUGUST	ANA MERCY CARE C	FNTER	TH KENWOO AKE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 15	2 895			
	increase range of n decrease in range of	notion and to prevent further of motion.				
	by: Based on observati review, the facility f interventions to ma	ent is not met as evidenced on, interview, and document ailed to follow care planned intain or improve range of sidents (R60) reviewed for		Corrected.		
	Findings include:					
	included aphasia (la the production or co hemiplegia (paralys hemiparesis (weak	indated, indicated diagnoses anguage impairment affecting omprehension of speech), is of one side of the body and ness of the entire side of the ebral infarction (stroke).				
	3/2/18, indicated R6 rarely or never under extensive assistance dressing, and perso identified functional (ROM) of upper (sh	num Data Set (MDS) dated 60 had no rejection of cares, erstood, and required be for bed mobility, transfers, onal hygiene. The MDS also limitation in range of motion woulder, elbow, wrist, and tremities (hip, knee, ankle,				
	(activities of daily liv R60 required exten mobility, transfers, grooming, and total also indicated R60	essessment (CAA) for ADLs ving) dated 3/12/18, indicated sive assistance with bed locomotion, dressing, toileting, assist with bathing. The MDS required supervision with t o proceed to the care plan.				
		der Report dated 3/29/18,				
Minnesota D STATE FORI	epartment of Health Vl		⁶⁸⁹⁹ N	/UKC11	If continuatior	n sheet 16 of 46

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00049	B. WING		03/	29/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
AUGUST	TANA MERCY CARE O	FNTER	TH KENWOOD AKE, MN 557			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 895	revealed an order for except during hygie every shift and pass to the right fingers, patient tolerance 10 and evenings). R60's care plan dat to maintain current increase ROM in rig interventions directo PROM to right upped digits, and to wear shygiene and when re plan also indicated frequently. R60's group sheet of indicated right hand hygiene and when re plan also indicated frequently. R60's Restorative N PROM to right finge to tolerance, 10 rep and p.m.) was not of 1/1/18- 1/31/18- mis 3/1/18- 3/28/18- mis 3/1/18- 3/28/18- mis During observation was seated in her v member (FM)-A. Re right hand (shortent with the fingers turr	or right hand splint at all times, ene when needs to be washed, sive range of motion (PROM) wrist, elbow and shoulder to) repetitions twice a day (days red 12/01/17, identified a goal ROM in upper extremity or ght upper extremity. The ed staff to provide gentle er extremity, shoulder, elbow, splint at all times except for needs to be washed. The care R60 refused to wear splint (nursing assistant instructions) d splint at all times except for needs to be washed, and t fingers, wrist, elbow, and o tolerance a.m. and p.m., 10 Nursing records indicated ers, wrist, elbow and shoulder, retitions twice daily (in a.m. consistently provided: ssed 14 times	2 895			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00049	B. WING		03/	03/29/2018	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE. ZIP CODE	03/	29/2010	
UGUST	ANA MERCY CARE (CENTER 710 SOL		D AVENUE			
			LAKE, MN 557		00000001011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 895	Continued From pa	age 17	2 895				
	stated R60 had a s the right side, and o FM-A further stated was not always on, On 3/28/18, at 8:32 was observed finish NA-H stated she as clothes on, washed bath," and assisted bed to wheelchair w was observed in R6 room. R60 was ob fingers inward towa	a 3/27/18, at 11:25 a.m. FM-A troke and had weakness on contracture of the right hand. d R60 had splints for hands bu "Like now," "Might be refusal" a.m. nursing assistant (NA)-F hing morning cares for R60. ssisted with putting residents d face, "Basically gave bed l R60 with transferring from with mechanical lift. No splint 60's hand or visible in the served to continue to hold ards palm, forming a fist.	t '-				
	9:00 a.m. R60 was wheelchair in her ro on R60's right hand NA-H asked R60 is nodded no. NA-H t	observed to be up in her observed to be up in her oom, no splint was observed d. NA-H was also in the room, s she wore a hand splint, R60 hen asked resident if she did e splint, and R60 nodded yes.					
	stated she consister range of motion ex- resident lays down stated she tried to o least once a day, s NA-H stated she has splint for R60. NA- group sheet from h the group sheet income	a 3/29/18, at 9:08 a.m. NA-H ently works with R60 and does ercises in the afternoon, as after lunch. NA-H further do twice a day, but does at he just doesn't have time. ad never seen a right hand H proceeded to remove the er pocket, and acknowledged licated right hand splint on at hygiene, and when needs to					
		a.m. NA-H went into R60's d to locate the hand splint, but d splint.	t				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00040	B. WING			
		00049			03/	29/2018
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST TH KENWOOL			
AUGUST	ANA MERCY CARE (CENTER	LAKE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 895	Continued From pa	age 18	2 895			
	registered nurse (F black hand splint. F was hiding or puttir RN-B stated, "Staff wear it, I know at o washcloth in her rig accepting a washcl recently notified the requested the phys splint, as staff repo hand splint. RN-B i had been on the ca was unable to dete been missing. RN- implementation of the programs were evan manager. RN-B ex included nursing as refusals, program i determination if still summary note was to find a recent qua quarterly note com did not address the On 3/29/18, at 1:52 her wheelchair in h washcloth was obs attempted to open to partially open it. put a washcloth he RN-B indicated cou in R60's hand. The PROM and AF policy dated 6/2016 limitations in function	the PROM, ROM, and walking aluated quarterly by the nurse plained the review process ssistant charting, resident mplementation frequency, I beneficial for resident, then a completed. RN-B was unable arterly summary note; the last pleted was dated 9/14/17, and				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		00049	B. WING	B. WING		03/29/2018	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
UGUST	ANA MERCY CARE C	SENTER	ITH KENWOOI LAKE, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 895	Continued From pa	ige 19	2 895				
	PROM may be com independent nursin order, perform ROM indicated in the res document PROM d record, document of and notify MD. SUGGESTED MET The director of nurs develop and/or revi procedures to ensu	d. The policy further directed ppleted by nursing staff as an g function and/or physician M exercises as ordered or torative nursing program, lone on electronic treatment changes in functional statues, THOD FOR CORRECTION: sing (DON) or designee could ew/revise policies and ure residents receive range of determined necessary by thei	r				
	individualized plan could provide educ on these polices an designee could do compliance. TIME PERIOD FOR	of care. The DON or designee cation to all appropriate staff nd procedures. The DON or random audits to ensure R CORRECTION: Twenty-one					
2 900	(21) days. MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			5/4/18	
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which	r				
	without pressure s pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical rates, and a physician they were unavoidable; and					
	B. a resident w	ho has pressure sores					

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00049	B. WING		03/2	9/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AUGUST	ANA MERCY CARE C	FNTFR	TH KENWOC AKE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 20	2 900			
		<pre>/ treatment and services to event infection, and prevent veloping.</pre>				
	by: Based on observati review, the facility fa assistance with rep and prevent develo for 1 of 1 (R17) resi pressure ulcers. Findings include: R17's quarterly Min 1/5/18, included dia disease, diabetes n disease, and periph MDS indicated no c extensive assistance (ADLs), no rejection ulcers. R17's annual MDS cognitive impairmen ADLS, no rejection ulcers. The Pressur Assessment (CAA) triggered due to ext mobility, frequently risk for skin alteratio	ent is not met as evidenced on, interview, and document ailed to provide timely ositioning to promote healing pment of new pressure ulcers dents reviewed with current imum Data Set (MDS) dated gnoses of cardiovascular hellitus type 2, chronic kidney eral vascular disease. The ognitive impairment, with activities of daily living n of cares and no pressure dated 7/7/17, indicated no nt, extensive assistance with of cares and no pressure the Ulcer Care Area dated 7/14/17, indicated CAA ensive assistance with incontinent of bladder, and at ons. R17 scored 15 on the used to predict pressure ulcer		Corrected		
	risk) placing resider The CAA also indica non-compliant with	nt at risk for pressure ulcers. ated R17 could be repositioning. Staff were to every 2 hours, and provide an				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/29/2018	
		00049	B. WING			
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
AUGUST	ANA MERCY CARE O	:ENTER	TH KENWOOI LAKE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE
2 900	Continued From pa	age 21	2 900			
	1/22/18, indicated a integrity related to i mellitus, history of p incontinence. R17 reposition at times R17 was also noted associated skin dan gluteal crease. Inte with setting of 6, pr her wheelchair, turn follow toileting sche moisture, and nurse weekly. The care p pressure ulcers to the					
	her room next to be	p.m. R17 was observed in ed in her wheelchair waiting for a air mattress was noted on				
	at her bedside. - At 6:40 p.m. cont - At 7:04 p.m. R17 answered the light - At 7:10 p.m. regis (RN)-B came out of wheeling her down taking R17 for a rid - At 7:30 p.m. RN- room. RN-B stated light she helped wit provided. - At 7:38 p.m. nurs	B wheeled R17 back to her when she answered the call th TV channel. No cares were sing assistant (NA)-C				
	answered R17's ca standing lift. NA-C bathroom and she	Il light and then went to get stated R17 needed to use the would take her to the toilet. had not been assisted with				

STATE FORM

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		00049	B. WING		03/29/2018		
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S				
AUGUST	ANA MERCY CARE	CENTER	TH KENWOOI LAKE, MN 55				
(X4) ID	_	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE	
2 900	Continued From pa	age 22	2 900				
+ 5 5 - 5	her room next to be stated she was up stated she had sor were better.	7 a.m. R17 was observed in ed in her wheelchair. R17 early around 6:00 a.m. R17 es on her bottom, but they was observed in the same					
	position. - At 7:40 a.m. R17 asleep in her whee - At 8:10 a.m. sam - At 08:26 a.m. sam entered R17's roor dental appointmen - At 8:30 a.m. R17 room. Eating indep - At 9:00 a.m. R17	was in the same position, elchair. e position. ne position. The social worker n to notify her of an upcoming t. was served breakfast in her pendently. was done with breakfast.					
	when R17 was last NA-H stated the ni repositioned her wi morning cares, and wheelchair. NA -H	H was interviewed regarding t assisted with repositioning. ght staff would have hen they assisted her with d transferred her into the verified she had not checked sitioning since she started					
	refused to be reported to license R17 refused to be with R17 and R17	- At 9:30 a.m. R17 had company visiting, and refused to be repositioned or toileted. NA-H reported to licensed practical nurse (LPN)-B that R17 refused to be repositioned. LPN-B spoke with R17 and R17 continued to refuse. LPN-B added that she explained the importance of					
	off-loading (relievin still refused, but ma -9:40 a.m. NA-H st will refuse cares. N toileted and reposit has open areas on	ng pressure to an area) but R17 ay allow at 10:00 a.m. ated R17 can get feisty and IA-H verified R17 should be tioned every 2 hours, and R17 her buttocks that are	7				
nnesota D	improving. Observa -At 11:38 a.m. NA- epartment of Health	ations ended. H stated R17 was finally					

Minnesota Department of Health STATE FORM

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STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00049	B. WING		03/29/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
AUGUST	ANA MERCY CARE C	SENTER	H KENWOOI AKE, MN 55			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF C		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	COMPLET DATE
2 900	Continued From pa	ige 23	2 900			
	repositioned and to NA.	repositioned and toileted at 11:00 a.m. by another NA.				
	On 3/29/18, at 07:45 a.m. R17 was observed in bed awake. R17 was positioned on her right side with a pillow behind her lower back. -At 8:01 a.m. observed RN-C/Nurse Educator perform morning cares. RN-C stated she completed R17's skin assessment upon a recent hospital return, and her pressure ulcers were much improved. R17 was turned on side and observed pressure ulcer (PU) to the right buttocks. A very small scabbed open area was observed to the left buttocks. The PU to the right buttocks was healed. R17's wheelchair was observed to have a pressure relieving cushion.					
	PU today. R17's Weekly Wou - 03/14/18, Readmi completed. Resider scale. Resident is r on buttocks. Reside	ound nurse would measure the nd Assessments: ission Skin risk assessment nt scored a 12 on the Braden noted to have pressure sores ent is able to make slight ndently, but does require				
	Elevate HOB [head sacral, coccyx or bu minimize time in be daily. Pressure redu [wheelchair]; pressure bed. Continue to fo	e significant repositioning. I of bed] as little as possible for uttocks ulcer prevention, ed, and moisturize dry/thin skin ucing cushion on W/C ure redistribution mattress on llow toileting schedules.				
	by care provider. N weekly. Complete a pressure areas of c	or moisture. Treat as ordered urse to complete body audit a new Braden assessment (for concern) and Tissue Tolerance en areas of concern are noted.				
	Notify MD [medical	doctor/NP [nurse practitioner] ntinue with plan of care.				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00049	B. WING		03/	29/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
AUGUST	ANA MERCY CARE C	SENTER	TH KENWOOI AKE, MN 55 [°]			
				PROVIDER'S PLAN OF		(YE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 900	Continued From pa	ige 24	2 900			
	this time r/t [related readmission followi of LLE [left lower ex- have an area to here 4.5 cm [centimeters redness with delaye noted area of abras cm x 3.5 cm. Area granulation; no evic tunneling, undermin current s/sx of infec Previous other ope scabbed to the sup area. Left (L) buttoo with abrasion area with pink/red granu undermining, tunne infection. Surround permanent staining blanchable skin. Re pain during assess bilateral buttocks, a then apply skin bar to be on ABx [antibi - 3/27/18, able to as afternoon. Residen her (R) buttock mea redness with delaye abrasion that was p	ssess resident's buttocks this t is noted to have an area to asuring 2.0 cm x 2.0 cm of ed blanching [stage 1]; previously noted is no longer				
	granulation; no evic tunneling, undermir current s/sx of infec buttocks superior m	ea presents with pink/red dence of slough or eschar, no ning, sinus tracts, induration or ction. No exudate noted. (L) nedial location with abrasion				
	x 1.2 cm. No evider	abbed over measuring 0.8 cm nce of undermining, tunneling, of infection. Surrounding skin				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00049	B. WING		03/29/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
AUGUST	IANA MERCY CARE C	ENTER	TH KENWOOD _AKE, MN 557			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTIO						
PRÉFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 900	Continued From pa	ge 25	2 900			
	purplish blanchable present with pain du wash bilateral butto dry and then apply s - 3/29/18, at 1:45 p. buttocks this afterna an area to her (R) b 1.4 cm of slight redu [stage 1]; abrasion no longer present to have area of drying buttocks with was e of the area. Area pr epithelialization; no no tunneling, under or current s/sx of in buttocks superior m area that was previo is now considered h scabbing noted to a presents with perma purplish blanchable present with pain du continue to follow a present to area, will time. Treatment: wa skin prep allow to d cream. On 3/29/18, at 12:1 verified the care pla repositioning every expect staff to provi R17 has a history o developed new pres	anent staining of darkened skin. Resident does not uring assessment. Treatment: cks, apply skin prep allow to skin barrier cream. m. able to assess resident's pon. Resident is noted to have puttock measuring 1.4 cm x ness with blanching noted that was previously noted is o area. Resident was noted to , flaking skin to bilateral assily removed with cleansing esents with pink/red evidence of slough or eschar, mining, sinus tracts, induration fection. No exudate noted. (L) hedial location with abrasion pusly scabbed over last week healed with no open areas or area. Surrounding skin anent staining of darkened skin. Resident does not uring assessment. Writer will nother week, if no changes considered healed at that ash bilateral buttocks, apply ry and then apply skin barrier 5 p.m. RN-B/Nurse Manager in directed staff to assist with 2 hours, and she would ide that care. RN-B added f pressure ulcers, and ssure ulcers after a recent beginning of March, which are				

Minneso	ota Department of He	ealth			-	AITROVED
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			A. BUILDING	·		
		00049	B. WING		03/2	9/2018
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
AUGUS	TANA MERCY CARE (CENTER	TH KENWOO LAKE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Continued From pa	age 26	2 900			
	A policy on pressur not provided by the	e ulcers was requested, but facility.				
	The director of nur- review and/or revis policies and proced receive care and a the development of pressure ulcers. The educate the approp policies/procedures develop a monitorin compliance.	THOD FOR CORRECTION: sing (DON) or designee could be the current pressure ulcer dures to ensure all residents ssistance as needed to preven f or further worsening of the DON or designee could priate staff on the s. The DON or designee could ng system to ensure ongoing R CORRECTION: Twenty-one	t			
2 920	MN Rule 4658.052	5 Subp. 6 B Rehab - ADLs	2 920			5/4/18
	comprehensive res home must ensure B. a resident who activities of daily liv	o is unable to carry out ring receives the necessary n good nutrition, grooming,				
	by: Based on observat review, the facility f bathing/showering residents (R3, R5, and personal groor (R214) reviewed for	ent is not met as evidenced ion, interview, and document failed to provide routine assistance for 7 of 11 R13, R15, R38, R56 and R60) ming for 1 of 11 residents or activities of daily living, and ent on staff for assistance.		Corrected.		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00049	B. WING		03/29/2018		
	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
		710 SOU	TH KENWOOI				
AUGUSI		MOOSE	LAKE, MN 55	767			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 920	Continued From pa	age 27	2 920				
	Findings include:						
	12/18/17, indicated not refuse cares, a two staff to bathe. directed staff to pro showers. An undat	nimum Data Set (MDS) dated I R3 was cognitively intact, did nd was totally dependent upon R3's care plan dated 12/12/17, pvide physical assistance with ed nursing assistant worksheet sist R3 with a shower weekly					
	stated, "They are a	on 3/26/18, at 3:05 p.m. R3 Iways short of staff," and not even get a weekly shower Ig to her.					
	2018, indicated sta with a shower on 1 1/26/18. However, signed off as given	History report for January Iff should have assisted R3 /5/18, 1/12/18, 1/19/18, and the 1/12/18, bath was not and the 1/19/18, bath was oone." Therefore, R3 went for a bout a shower.	L				
		History report for February had received a weekly shower	-				
	indicated staff shous shower on 3/2/18,	History report for March 2018, uld have assisted R3 with a 3/9/18, 3/16/18, and 3/23/18. /er was not signed off as being , or 3/23/18.					
	was cognitively inta required total staff care plan dated 10 total assist of 2 for	S dated 12/19/17, indicated R5 act, did not reject cares and assistance with bathing. R5's /21/16, indicated she required bathing. An undated nursing et directed a tub bath every					

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00049	B. WING		03/29/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	1	
AUGUST	ANA MERCY CARE	CENTER	TH KENWOOI LAKE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PR		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ACTION SHOULD BE CONTROL CONTR	
2 920	Continued From pa	age 28	2 920			
	Monday.					
	stated she typically fussy about who gi often not enough s weekly bath. R5 st abdominal folds ar	on 3/26/18, at 11:58 a.m. R5 y does not like to bathe, and is ives her a bath, but that there is staff available to give her a ated she has a rash in her nd under her breasts, and that ept clean or the rash, "Gets	3			
	2018, indicated R3 on 1/1/18, 1/8/18, However, the repo received one bath The other dates we	History report for January should have received a bath 1/15/18, 1/22/18, and 1/29/18. rt indicated R5 had only the entire month on 1/15/18. ere either not answered, or one-Resident Refused."				
	2018, indicated R5 with a bath on 2/5/ 2/26/18. Two of the	History report for February 5 should have been assisted 18, 2/12/18, 2/19/18, and ose dates were marked as not ked at all. R5 had only received ary on 2/19/18.	ł			
	indicated R5 shoul bath on 3/5/18, 3/1 Two of those dates	History report for March 2018, Id have been assisted with a 2/18, 3/19/18, and 3/26/18. Is were marked as not done, ered. R5 had only received a				
	was cognitively inta was totally depend care plan dated 11 extensive assistan nursing assistant v	6 dated 12/30/17, included he act, did not reject cares, and lent upon staff to bathe. R13's /4/15, indicated he required ce for bathing. An undated vorksheet indicated R13 should bath on Wednesdays and a	1			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00049	B. WING		03/29/2018	
AME OF F	ROVIDER OR SUPPLIER		ADDRESS, CITY, S	TATE, ZIP CODE		
UGUST	ANA MERCY CARE (SENTER	OUTH KENWOOD E LAKE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From pa	age 29	2 920			
	second bath on Sa	turdays.				
	stated he is suppose but there is not end stated even if there pulled from giving b other things. R13 s bath last week, this not kept track of wh received the sched R13's Point of Care 2018, indicated he baths on Wednesd Saturday baths was R13's Point of Care 2018, indicated R1 scheduled Wedness baths were docume R13's Point of Care 2018, indicated he	e History report for January had received all scheduled ays, but no documentation o s provided. e History report for February 3 had missed one out of four day baths, and no Saturday	k, d			
	Saturdays, with two documented. R15's quarterly MD had moderate cogr cares, and was tota bathing. R15's care two baths per week assistant care shee	b "partial bed bath" OS dated 1/2/18, indicated R1 nitive impairment, did not reje ally dependent upon staff for b plan directed staff to provide c. An undated nursing et indicated R15 was to be	ect			
	Saturdays. When interviewed	nesday, and an extra bath on on 3/27/18, at 2:19 a.m. R15 eerns over not having enough				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED		
		00049	B. WING		03/29/2018			
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE				
AUGUSTANA MERCY CARE CENTER 710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767								
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE		
2 920	Continued From pa	age 30	2 920					
	2018, indicated he	e History report for January had received only three of the ths,and none of the Saturday						
	2018, indicated he four Wednesday ba	e History report for February had only received three of the aths and none of the Saturday had refused once.						
	2018, indicated he Wednesday and or An undated, untitle	e History report for March had received only one ne Saturday bath this month. d copy with handwriting received another bath on on 3/9/18.						
	indicated R38 had did not refuse care assistance from sta dated 1/17/18, dire bathing. An undate	hange MDS dated 2/4/18, severe cognitive impairment, s, and required total aff for bathing. R38's care plan cted staff to assist with ed nursing assistant worksheet Ild be assisted with bathing on	t					
	stated she did not f available to meet h	on 3/26/18, at 1:59 p.m. R38 feel there was enough staff er needs. R38 did not know vived a bath, but didn't think it						
		8, Point of Care History report received one of two scheduled used the other.						
	R38's February 20 two out of four sch	18, indicated R38 had received eduled baths.	t					

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00049	B. WING		03/29/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
AUGUST	ANA MERCY CARE	CENTER	TH KENWOOD			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From pa	age 31	2 920			
		Point of Care History report received two out of four and refused one.				
	was cognitively inta required physical h care plan dated 5/ with bathing twice Mondays. An unda worksheet directed	DS dated 3/5/18, indicated R56 act, did not refuse cares, and elp in part of bathing. R38's 13/15, directed staff to assist a week on Fridays and ted nursing assistant I staff to assist with bathing on an extra bath on Saturdays.				
	stated they are, "S bath days will com	on 3/26/18, at 11:22 a.m. R56 hort of help for aides, some e and go without a bath." R56 t get, "Made up," if missed, and g to her.	Ŀ			
	2018, indicated she	e History report for January e had received five of five and two of four Saturday				
	2018, indicated she	e History report for February e had received three of four and two of four Saturday				
	2018, indicated she Wednesday baths,	e History report for March e had received two of four and no Saturday baths. An orm indicated she had received n 3/15/18.				
	had severe cognition cares, and required bathing. R60's care	dated 3/2/18, indicated R60 ve impairment, did not refuse d total staff assistance for e plan directed staff to provide ce with bathing on Tuesdays.				

	NT OF DEFICIENCIES OF CORRECTION	Alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00049	B. WING		03/29/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
AUGUST	TANA MERCY CARE C	SENTER	TH KENWOOD			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 920	Continued From pa	ige 32	2 920			
	An undated nursing staff to bath R60 or	g assistant worksheet directed n Tuesdays.				
	stated the staff is, " get a bath on Tueso and set her hair after pull the bath aide if stated today is Tue had just found out t give baths today. R good when she doo week. R60's Point of Care 2018, identified she of the five Tuesday twenty-one days be R60's Point of Care 2018, identified she	on 3/27/18, at 11:03 a.m. R60 Really short," and she used to day, then they would come in er breakfast. R60 stated they someone calls in sick. R60 sday, and no bath yet, and she they did not have anyone to 60 stated she does not feel esn't get a bath at least every e History report for January e had received a bath three out s, missing a bath for etween 1/9/18, and 1/30/18.	t			
	R60's Point of Care 2018, identified she on 3/3/18, and 3/4/ However, there was report identifying ar list dated 3/26/18, is one bath on 3/27/18	e History report for March e had received an ordered bath 18, due to scheduled surgery. s no Point of Care History ny other baths. A Master Bath dentified R60 had received 8. No time was identified.				
	dated February 28,	ent Council Meeting Notes 2018, noted a concern over I due to staff shortages.				
	nursing assistant (N short staffed, the ba the floor doing nurs	on 3/27/18, at 3:47 p.m. NA)-B stated they are often ath aide gets pulled to work on ing assistant duties, and then it done. The nursing assistants				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00049	B. WING		03/29/2018		
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
AUGUST	ANA MERCY CARE C	SENTER	TH KENWOOD				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ACTION SHOULD BE COMP TO THE APPROPRIATE DAT		
2 920	Continued From page 33		2 920				
	are not able to do them, and the baths get missed.						
	stated the bath aide	on 3/27/18, at 3:54 p.m. NA-C e gets pulled, "A lot," and they baths done the next day, but it appen.					
	stated they do not h afternoon shift, and	on 3/27/18, on 3:59 p.mNA-A nave a bath aide on the I they are unable to get baths get done on the day shift.					
		on 3/27/19, at 4:02 p.m. NA-D always get done, and they catch up on them.					
	stated they can usu	on 3/28/18, at 7:05 a.m. NA-G Ially get the work done but it is Is do not always get done.					
		on 3/28/18, at 7:57 a.m. NA-H e had called in for the day, and t done that day.					
	stated she had offe	on 3/28/18, at 9:22 a.m. NA-I ared to do baths today for her unteers, "They will get done					
	stated she is often gets pulled very fre	on 3/29/18, at 7:39 a.m. NA-F the assigned bath aide, but quently. NA-F stated she can't I meet everyone's other needs					
	licensed practical n	on 3/29/18, at 10:40 a.m. urse (LPN)-A stated she is e nursing assistants with oo busy herself.					

00049 AME OF PROVIDER OR SUPPLIER	ATION NUMBER: A. BL			PLETED
AME OF PROVIDER OR SUPPLIER	B. W	NG		
			03/2	29/2018
	STREET ADDRESS	, CITY, STATE, ZIP CODE		
UGUSTANA MERCY CARE CENTER	710 SOUTH KE MOOSE LAKE,	NWOOD AVENUE MN 55767		
PREFIX (EACH DEFICIENCY MUST BE PREC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED		I'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
2 920 Continued From page 34	2 9	20		
When interviewed on 3/29/18, at stated they pull the bath aide at NA-K stated there was no way to them. NA-K stated sometimes s stay late to catch up, but not very	east weekly. o catch up on he is asked to			
When interviewed on 3/29/18, at 8:01 a.m. registered nurse (RN)-A stated if they have a nursing assistant call in, they will pull the bath aide from doing baths to replace them. If this happens the nursing assistants working should do all the baths. They do not always report when the baths have not been completed. Occasionally, a nursing assistant will report a bath had not been completed, and she reports this to the afternoon shift so that they can try and do it. This is not followed up on to see if the resident actually received a bath.	they have a pull the bath them. If this working should ays report when ted. t will report a nd she reports they can try and to see if the			
When interviewed on 3/28/18, at administrator stated the facility w baths not always getting done, th addressing the issue in their qua and assurance (QAA) committee nursing (DON) stated they are si they try to get an extra person in have a bath aide, or will try and g stay late and try to get the baths	vas aware of ney are currently lity assessment e. The director of till working on it, if they do not get someone to			
A facility policy entitled Apollo Tu Care dated 7/15, directed the fre bath/shower will be weekly or as each resident, to meet the hygie resident.	equency of requested by			
R214's 14-day MDS dated 3/5/1 had severe cognitive impairment extensive assistance with person	t, and required			
R214's Social Services assessm	ent completed			

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		00049	B. WING		03/	29/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
AUGUST	ANA MERCY CARE (CENTER	TH KENWOOD			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLETI DATE
2 920	Continued From pa	age 35	2 920			
	in her appearance. [activities of daily lip plan dated 3/9/18, assistance for dress On 3/26/18, at 3:54 have numerous, vis present on her chir neck line. During s 3/27/18, at 7:23 p.r R214 continued to	cluding, "Resident takes pride Staff assist with ADLs ving]." Further, R214's care identified R216 required total using, bathing, and grooming. If p.m. R214 was observed to sible white colored hairs which extended down her subsequent observations on m. and 3/28/18, at 7:16 a.m. have visible, white colored on her chin and extending				
	stated staff comple as there was a lot I NA-A expressed R hair, however, obse	on 3/28/18, at 9:41 a.m. NA-A eted R214's grooming for her R214 can't do for herself. 214 typically did not have facia erved her and stated there was should have been removed cares.				
	stated residents sh designated bath da did not have any pr	n 3/28/18, at 1:40 p.m. RN-A ould be shaved on their ay(s). RN-A explained R214 references for facial hair, and it removed as residents, "Need ."	t			
	A facility policy on g was not provided.	grooming and personal hygiene	e			
	director of nursing develop policies ar residents receive a	and grooming as determined	•			

STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY IPLETED
		00049	B. WING		03/29/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
AUGUST	ANA MERCY CARE C	FNTER	TH KENWOOD _AKE, MN 557			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 920	Continued From pa	ge 36	2 920			
	The DON or design appropriate staff on	ee could educate all these policies and ON or designee could develop				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21830	MN St. Statute 144. Residents of HC Fa	.651 Subd. 10 Patients & ac.Bill of Rights	21830			5/4/18
	Subd. 10. Particip notification of family	ation in planning treatment; / members.				
	in the planning of the includes the opport alternatives with inco- opportunity to reque- care conferences, a family member or or both. In the event to present, a family me- chosen by the reside conferences. (b) If a resident we unconscious or con- communicate, the fi- efforts as required to either a family mem- writing by the reside an emergency that admitted to the facili- family member to p- planning, unless the to believe the reside	I have the right to participate heir health care. This right unity to discuss treatment and dividual caregivers, the est and participate in formal and the right to include a ther chosen representative or hat the resident cannot be ember or other representative lent may be included in such who enters a facility is natose or is unable to acility shall make reasonable under paragraph (c) to notify ther or a person designated in ent as the person to contact in the resident has been lity. The facility shall allow the articipate in treatment e facility knows or has reason ent has an effective advance trary or knows the resident has				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00049	B. WING		03/	29/2018
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
AUGUST	ANA MERCY CARE O	ENTER	TH KENWOOD LAKE, MN 557			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21830	Continued From pa	ge 37	21830			
	member included in treatment planning. After					
		ember but prior to allowing a				
	family member to p	articipate in treatment				
		/ must make reasonable				
		vith reasonable medical				
	•	ne if the resident has				
		ce directive relative to the re decisions. For purposes of				
		asonable efforts" include:				
		e personal effects of the				
	resident;					
		e medical records of the				
		resident in the possession of the facility;				
	(3) inquiring of any emergency contact or family member contacted under this section					
		tacted under this section thas executed an advance				
		er the resident has a				
		the resident normally goes for				
	care; and	, ,				
		e physician to whom the				
		oes for care, if known,				
		nt has executed an advance				
		y notifies a family member or ency contact or allows a family				
		ate in treatment planning in				
		is paragraph, the facility is not				
		r damages on the grounds tha				
	the notification of th	ne family member or				
		or the participation of the				
		improper or violated the				
	patient's privacy rig					
		asonable efforts to notify a lesignated emergency contact				
		empt to identify family	'			
		gnated emergency contact by				
		onal effects of the resident				
		cords of the resident in the				
		acility. If the facility is unable				
	to notify a family me	ember or designated				

Minnesota Departme	nt of Health					
STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION	· · ·	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMPI	
		00049	B. WING		03/2	9/2018
NAME OF PROVIDER OR S	UPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AUGUSTANA MERCY	CARE CENT	FR	H KENWOO AKE, MN 5			
PREFIX (EACH DE	FICIENCY MUS	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	ON SHOULD BE COMPLE IE APPROPRIATE DATE	
21830 Continued F	rom page 3	8	21830			
admission, social servic agency that the facility h member or county social enforcemen identifying a designated service age that assists subdivision damages of the family m participation	the facility sl ce agency of the resident as been una designated al service ag t agency sh and notifying emergency ncy or local a facility in is not liable in the ground member or en of the famil	in 24 hours after the hall notify the county r local law enforcement t has been admitted and able to notify a family emergency contact. The gency and local law all assist the facility in a family member or contact. A county social law enforcement agency implementing this to the resident for ls that the notification of mergency contact or the ly member was improper privacy rights.				
by: Based on in facility failed preferences (R12, R13, to have two failed to cor choices for residents (F desired add Findings ind R12's annu 12/29/17, in not reject ca with bathing R12's care	terview and to ensure r were honor R15 and R5 baths week nprehensive bathing sche (22) reviewe itional bathin clude: al Minimum dicated she ares, and rec ban dated 1	as not met as evidenced document review, the esident choices and red for 4 of 5 residents 6) who expressed desire ly. In addition, the facility by assess and afford edule(s) for 1 of 5 red for choices and who ing during the week. Data Set (MDS) dated was cognitively intact, did quired staff assistance		Corrected.		
Minnesota Department of He		,		1		

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00049	B. WING		03/	29/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
AUGUST	ANA MERCY CARE C	SENTER	TH KENWOOD LAKE, MN 557			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
21830	Continued From pa	ige 39	21830		- ·)	
	and assistance/sup undated nursing as	ce in and out of shower room pervision for shower. R12's sistant worksheet indicated a shower on Wednesdays and Saturdays.				
	stated the staff, "W concern that not all to this. When interv R12 stated she has	on 3/27/18, at 9:55 a.m. R12 ork short." R12 expressed cares are being provided due viewed on 3/2/18, at 10:10 a.m. s told the staff she would like to a week, but this rarely				
	indicated one out o	8, Point of Care History report f the five Wednesday baths and the facility did not provide aturday baths.				
	indicated three out	18, Point of Care History report of the four weekly baths were esdays, and three out of four saturdays.				
	indicated two out of had received a bath untitled sheet of pa	Point of Care History report f the four Wednesdays she n. A handwritten undated, per indicated R12 had f four Saturday baths.				
	was cognitively inta was totally depended care plan dated 11/ extensive assistant nursing assistant w be assisted with a b second bath on Sat	dated 12/30/17, included he loct, did not reject cares, and ent upon staff to bathe. R13's 4/15, indicated he required be for bathing. An undated forksheet indicated R13 should bath on Wednesdays and a turdays. R13's Care ary dated 1/11/18, indicated a				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00049			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00049	B. WING	B. WING		29/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
AUGUST	ANA MERCY CARE O	SENTER	TH KENWOOD			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21830	Continued From pa	age 40	21830			
	stated he was supp week, but there wa R13 stated even if they get pulled from to do other things. I a bath last week, th had not kept track of received his schedu		e			
	R13's Point of Care History report for January 2018, showed he had received all scheduled baths on Wednesdays, but no documentation of Saturday baths were provided.					
	2018, showed R13	e History report for February had missed one out of four day baths, and no Saturday ented.				
	2018, showed he h	e History report for March ad received two out of four and no full baths on o "partial bed bath"				
	moderate cognitive cares, and was tota bathing. R15's care two baths per week care sheet indicate	S dated 1/2/18, indicated impairment, did not reject ally dependent upon staff for plan directed staff to provide c. An undated nursing assistan d R15 was to be bathed every iven an extra bath on				
		on 3/27/18, at 2:19 a.m. R15 erns over not having enough				

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00049	B. WING		03/29/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
AUGUST	ANA MERCY CARE O	SENTER	ITH KENWOOD LAKE, MN 557			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21830	•	-	21830			
	2018, indicated he	e History report for January had received three of the five and none of the Saturday				
	2018, indicated he Wednesday baths	e History report for February had received three of the four and none of the Saturday fon indicated R15 refused				
	2018, indicated he and one Saturday t untitled copy with h	e History report for March had received one Wednesday path month. An undated, andwriting indicated R15 had ath on on 3/3/18, 3/7/18 and				
	was cognitively inta required physical h care plan dated 5/1 with bathing twice a Mondays. An unda worksheet directed Wednesdays, with R56's Care Confer	S dated 3/5/18, indicated she act, did not refuse cares, and elp in part of bathing. R56's 3/15, directed staff to assist a week on Fridays and ted nursing assistant staff to assist with bathing on an extra bath on Saturdays. ence Summary dated 3/8/18, nce for two baths per week.				
	stated they are "Sh bath days will come	on 3/26/18, at 11:22 a.m. R56 ort of help for aides, some and go without a bath." R56 get "Made up" if missed, and g to her.				
	2018, indicated she	e History report for January e had received five of five and two of four Saturday				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00049	B. WING		03/29/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
AUGUST	ANA MERCY CARE (CENTER	TH KENWOOL			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21830	Continued From pa	age 42	21830			
	2018, indicated she	e History report for February e had received three of four and two of four Saturday				
	2018, indicated she Wednesday baths,	e History report for March e had received two of four and no Saturday baths. An orm indicated she had received n 3/15/18.				
	nursing assistant (I short staffed and th work on the floor d baths do not get do	on 3/27/18, at 3:47 p.m. NA)-B stated they are often ne bath aide gets pulled to oing nurse aide duties, and the one. NA-B continued to state nts are not able to do the t missed.	•			
	stated bath aide ge	on 3/27/18, at 3:54 p.m. NA-C ets pulled, "A lot," and they will ns done the next day, but it appen.				
	stated they do not afternoon shift, and	on 3/27/18, on 3:59 p.m. NA-A have a bath aide on the d they are unable to get baths t get done on the day shift.				
		on 3/27/19, at 4:02 p.m. NA-D t always get done, and they catch up on them.				
	stated they can usu	on 3/28/18, at 7:05 a.m. NA-G ually get the work done but it is ns do not always get done.				
		on 3/28/18, at 7:57 a.m. NA-H e had called in for the day, and t done that day.				

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 03/29/2018		
		00049					
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	•		
AUGUST	ANA MERCY CARE (CENTER	ITH KENWOOD				
MOOSE LAKE, MN 55767 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTI							
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	(X5) COMPLET DATE	
21830	Continued From pa	age 43	21830				
	stated she had offe	on 3/28/18, at 9:22 a.m. NA-I ered to do baths today for her lunteers, "They will get done					
	stated she is often gets pulled very fre	on 3/29/18, at 7:39 a.m. NA-F the assigned bath aide but equently. She can't get baths resident's other needs.					
	licensed practical r	on 3/29/18, at 10:40 a.m. hurse (LPN)-A stated she is e nurse aides with bathing as self.					
	stated they pull the there is no way to c	on 3/29/18, at 7:56 a.m. NA-K bath aide at least weekly, and catch up on the baths. NA-K she is asked to stay late to ery often.					
	registered nurse (F nursing assistant c aide from doing ba happens, the nursi do all the baths. Th the baths have not Occasionally, a nur bath had not been this to the afternoo do it. This is not fol	on 3/29/18, at 8:01 a.m. RN)-A stated if they have a all in, they will pull the bath ths to replace them. If this ng assistants working should ney do not always report when been completed. rsing assistant will report a completed, and she reports n shift so that they can try and lowed up on to see if the ceived a bath on the evening					
	administrator state baths not always g	on 3/28/18, at 9:48 a.m. the d the facility was aware of etting done, they are currently ue in their quality assessment					

STATEMENT OF DEFICIENCIES (2 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 03/29/2018	
		00049				
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
AUGUST	ANA MERCY CARE O	CENTER	TH KENWOOD LAKE, MN 557			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21830	Continued From pa	age 44	21830			
	nursing (DON) stat they try to get an ex have a bath aide, o stay late and try to	AA) committee. The director of ed they are still working on it, xtra person in if they do not or will try and get someone to get the baths done.				
	Care dated 7/15, di bath/shower will be	led Apollo Tub, Basic Nursing irected the frequency of weekly or as requested by neet the hygiene needs of each				
	had moderate cogr	dated 3/14/18, identified R62 nitive impairment, required ce with transfers, and total ching.				
	explained she enjo she could have mo however, "Everybo she would like to ha nobody had ever as	a 3/26/18, at 1:04 p.m. R62 yed having a bath and wished re than one per week, dy gets it that way." R62 stated ave two baths per week, but sked or questioned her about ences since she came to the	I			
	3/28/18, identified I the past weeks. R6 on a weekly basis. Preference Sheet s ask her preference when completing o any assessment or	e History report printed R62's completed bath(s) for 2 had a bath completed only Further, R62's Resident signed 2/28/18, directed staff to between a bath or shower ne for R62, however, lacked input on R62's choice or ing. A section labeled, "Other,"				
	evidence R62 had	ord was reviewed and lacked been assessed or afforded g schedule(s) since admitting				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			/. Doilbine		03/29/2018	
00049		00049	B. WING			
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
AUGUST	ANA MERCY CARE (CENTER	TH KENWOOD			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21830	Continued From pa	age 45	21830			
	to the nursing hom	e.				
	(RN)-A was intervie for bathing schedul resident admits to t added to the bathin week" and should t preferences for add preferences for bat recorded on it addi times she desired a A facility Resident f 8/2013, directed all " are provided w preferences." A pro directed, "On admin asked questions re sleep [and] wake ti	21 p.m. registered nurse ewed about the facility process les. RN-A stated when a the nursing home, they are ag schedule for "at least once a be asked about their ditional bathing using a Resident Preference Sheet). 2's completed sheet and stated thing usually would be ang it should say how many a bath during the week. Preferences policy dated I residents of the nursing home ith choices regarding their bocedure was listed which ssion[,] all residents will be agarding their preferences for mes, bathing and activities preferences were then to be	a 1			
	director of nursing develop policies an residents choices a designee could edu these policies and designee could dev ensure ongoing cou	THOD OF CORRECTION: The (DON) or designee could ad procedures to ensure are honored. The DON or ucate all appropriate staff on procedures. The DON or velop monitoring systems to				
	(21) days.	A CORRECTION. Twenty-one				