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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: N91W

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00627

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245330**

2.STATE VENDOR OR MEDICAID NO.
(L2) **943188800**

3. NAME AND ADDRESS OF FACILITY
(L3) **COUNTRY MANOR HEALTH & REHAB CTR**
(L4) **520 FIRST STREET NORTHEAST**
(L5) **SARTELL, MN** (L6) **56377**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **3/20/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **165** (L18)

13.Total Certified Beds **165** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	165			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Christine Bodick-Nord, HFE NE II 03/262014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist 03/312014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/31/2014
(L33)

DETERMINATION APPROVAL

At the time of the standard survey completed January 28, 2014, the facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety which is a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required as evidenced by the attached CMS-2567.

This Department imposed the following remedy:

- State Monitoring effective February 18, 2014. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F157, effective January24, 2014 (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F309, effective January24, 2014 (42 CFR 488.430 through 488.444)

On 03/06/14 The Department of Public Safety and on 03/20/14 the Department of Health completed a Post Certification Revisit (PCR). Based on the PCR, it has been determined that the facility had achieved substantial compliance pursuant to the 1/28/2014 extended survey. Refer to the CMS 2567B for both health and life safety code. Effective 2/28/2014 the facility is certified for 165 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245330

March 26, 2014

Mr. Brian Kelm, Administrator
Country Manor Health & Rehab Ctr
520 First Street Northeast
Sartell, MN 56377

Dear Mr. Kelm:

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 February 28, 2014, the above facility is certified for:

165 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 165 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,

Kate Johnston

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 31, 2014

Mr. Brian Kelm, Administrator
Country Manor Health & Rehab Ctr
520 First Street Northeast
Sartell, MN 56377

RE: Project Number S5330024

Dear Mr. Kelm:

On February 13, 2014, we informed you that the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety and that the following enforcement remedy was being imposed:

- State Monitoring effective February 18, 2014. (42 CFR 488.422)

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of February 13, 2014:

- Civil money penalty for the deficiency cited at F157, (42 CFR 488.430 through 488.444)

- Civil money penalty for the deficiency cited at F309, (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an extended survey completed on January 28, 2014. The most serious deficiency was found to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required.

On March 20, 2014, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on January 28, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 28, 2014. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on January 28, 2014, as of February 28, 2014.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective February 28, 2014.

However, as we notified you in our letter of February 13, 2014, 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 is

prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 28, 2014.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of February 13, 2014:

- Civil money penalty for the deficiency cited at F157, remains in effect (42 CFR 488.430 through 488.444)

- Civil money penalty for the deficiency cited at F309, remains in effect (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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

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

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245330	A. Building B. Wing — 02 - 2011 TWO STORY ADDITION	3/6/2014

Name of Facility	Street Address, City, State, Zip Code
COUNTRY MANOR HEALTH & REHAB CTR	520 FIRST STREET NORTHEAST SARTELL, MN 56377

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0056	Correction Completed 02/18/2014	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By PS/KJ	Date: 3/26/2014	Signature of Surveyor: 27200	Date: 3/6/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 1/23/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245330	A. Building B. Wing	3/20/2014

Name of Facility	Street Address, City, State, Zip Code
COUNTRY MANOR HEALTH & REHAB CTR	520 FIRST STREET NORTHEAST SARTELL, MN 56377

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **02/14/2014**	ID Prefix **F0161** Reg. # **483.10(c)(7)** LSC	Correction Completed **01/30/2014**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **02/28/2014**
ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **02/28/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **02/14/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **02/14/2014**
ID Prefix **F0501** Reg. # **483.75(i)** LSC	Correction Completed **02/14/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PK/KJ	3/26/2014	29437	3/20/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
1/28/2014	

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00627	A. Building B. Wing	3/20/2014

Name of Facility	Street Address, City, State, Zip Code
COUNTRY MANOR HEALTH & REHAB CTR	520 FIRST STREET NORTHEAST SARTELL, MN 56377

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20265** Reg. # **MN Rule 4658.0085** LSC	Correction Completed **02/14/2014**	ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp. 1** LSC	Correction Completed **02/14/2014**	ID Prefix **21235** Reg. # **MN Rule 4658.0700 Subp. 2 C** LSC	Correction Completed **02/14/2014**
ID Prefix **21390** Reg. # **MN Rule 4658.0800 Subp. 4 A-I** LSC	Correction Completed **02/14/2014**	ID Prefix **21990** Reg. # **MN St. Statute 626.557 Subd. 4** LSC	Correction Completed **02/28/2014**	ID Prefix **22000** Reg. # **MN St. Statute 626.557 Subd.** LSC	Correction Completed **02/28/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PK/KJ	03/26/2014	29437	3/20/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/28/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: N91W

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00627

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245330**

2.STATE VENDOR OR MEDICAID NO.
(L2) **943188800**

3. NAME AND ADDRESS OF FACILITY
(L3) **COUNTRY MANOR HEALTH & REHAB**
(L4) **CTR 520 FIRST STREET NORTHEAST**
(L5) **SARTELL, MN** (L6) **56377**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/28/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **165** (L18)

13.Total Certified Beds **165** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	165			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Christine Bodick-Nord, HFE NE II — 03/03/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 03/29/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 3/31/2014 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

CCN: 24-5330

At the time of the standard survey completed January 28, 2014, the facility was not in substantial compliance with the participation requirements and the conditions in the facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required as evidenced by the attached CMS-2567.

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Therefore, this Department is imposing the following remedy:

- State Monitoring effective February 18, 2014. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

-Civil money penalty for the deficiency cited at F157, effective January24, 2014 (42 CFR 488.430 through 488.444)

-Civil money penalty for the deficiency cited at F309, effective January24, 2014 (42 CFR 488.430 through 488.444)

Refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8187

February 13, 2014

Mr. Brian Kelm, Administrator
Country Manor Health & Rehabilitation Center
520 First Street Northeast
Sartell, Minnesota 56377

RE: Project Number S5330024

Dear Mr. Kelm:

On January 28, 2014, an extended survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not

immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on January 28, 2014, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

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:

Sarah Grebenc, Unit Supervisor
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301

Telephone: (320) 223-7365
Fax: (320) 223-7348

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective February 18, 2014. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F157, effective January24, 2014 (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F309, effective January24, 2014 (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(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 an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Country Manor Health & Rehab Ctr is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective January 28, 2014. This prohibition remains in effect for the specified period even though substantial compliance is attained. 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.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an

administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

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

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

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are

ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedy be imposed:

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

If substantial compliance with the regulations is not verified by April 28, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of

this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 28, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

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

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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	245330	A. BUILDING _____ B. WING _____	01/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY MANOR HEALTH & REHAB CTR	520 FIRST STREET NORTHEAST SARTELL, MN 56377

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A recertification survey was conducted by the Minnesota Department of Health on January 21st, 22nd, 23rd, 24th, 25th, 26th, 27th and 28th, 2014. The survey resulted in an Immediate Jeopardy (IJ) at F157 and F309 related to the facility's lack of clinical monitoring of significantly elevated blood sugar levels and failure to notify the physician which resulted in the high potential for harm or death which began on 9/19/13. Facility staff were notified of the IJ on January 24, 2014, at 4:32 p.m. The IJ was removed on January 28, 2014, at 3:15 p.m., however non-compliance remained at the lower s/s of a G. An extended survey was completed on 1/24/14 to 1/28/14.	F 000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusions In the statement of deficiencies. The facility has appealed the deficiencies and licensing violations. This Plan of Correction is prepared and executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility's allegation of compliance.	
F 157 SS=K	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dan C. Kline | TITLE: Adm/CEO | (X6) DATE: 2-26-2014

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

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F 157	Continued From page 1 physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure changes in clinical status including significantly elevated blood sugars and/or results that were a change of condition were promptly reported to the physician for 2 of 28 residents (R300 and R355) with diabetes. The lack of clinical monitoring and failure to notify the physician resulted in an immediate jeopardy situation with the potential to affect 53 diabetic residents who required blood glucose monitoring. This resulted in actual harm for R300 who required emergency medical interventions on	F 157	Plan of Correction F157 1. Licensed nursing staff contacted physicians of residents who are diabetic with glucometer checks and requested when the physician wanted to be notified of low or high blood sugars. (Implemented 1/27/14). 2. Licensed nursing staff audited all diabetic resident charts and reviewed for change of condition and physician notification. (Implemented 1/25/14). 3. Licensed nursing staff were re-educated on signs and symptoms of hyper/hypoglycemia and normal lab values. (Implemented 1/28/14).	

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F 157	Continued From page 2 9/19/13, and expired. The immediate jeopardy began on 9/19/13, when the facility failed to promptly notify the physician of elevated blood sugars and was identified on 1/24/14. The director of nursing (DON), vice president of long term care and rehab (rehabilitative) operations, and director of rehab were notified of the immediate jeopardy on 1/24/14, at 4:32 p.m. The immediate jeopardy was removed on 1/28/14, at 3:15 p.m. but non compliance remained at the lower scope level of a G (actual harm that is not immediate jeopardy). Findings include: R300 was admitted to the facility on 9/10/13, after a hospitalization for acute renal failure, diabetic ketoacidosis (a life-threatening complication when the body does not produce enough insulin), and a brain aneurysm with ventriculoperitoneal shunt (used to take excess fluid from brain, and "shunt" or divert it to the abdomen for absorption) placement. While hospitalized, R300 had blood sugars greater than 1,100 milligrams per deciliter (mg/dL) which required a continuous insulin drip to return to normal levels. R300's diagnoses per the hospital discharge summary dated 9/10/13, included but were not limited to Type 1 diabetes, hypertension and stroke. The admission Minimum Data Set (MDS) completed on 9/23/13, identified R300's cognitive skills for decision making were severely impaired, did not speak, and a brief interview for mental status (BIMS) was not completed because R300 was rarely understood.	F 157	4. The Diabetic Policy and Change of Condition Policy were updated to include the following for diabetic residents with glucometer checks: *The physician will be contacted and asked to identify parameters for physician notification on new diabetic admissions who receive glucometer checks. *New admissions with diabetes will be asked if they can tell when their blood sugar is high or low and the information will be documented. The above policy was reviewed and approved by the Medical Director. Licensed nursing staff was re-educated on the updated Diabetic and Change of Condition Policies. (1/28/14)	

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F 157	Continued From page 3 R300's physician orders from the 9/13 medication administration record included: Novolog (a quick acting insulin) One unit per carbohydrate consumed with each meal Novolog sliding scale insulin with all meals per blood sugar results Lantus (a long acting insulin) 20 units with breakfast and a bedtime Glucometer (blood sugar) checks four times a day Ensure Clear 120 milliliters (mL) four times a day Osmolite 1.5 mL/hour for nine hours at night via enteral feeding tube (g-tube) Review of R300's glucometer record for 9/13 included the following blood sugars: From 9/10/13 to 9/17/13 the results ranged from 71-386 with one reading of 409. On 9/18/13, at 7:00 a.m. the blood sugar was 392. At 11:00 a.m. it was 525. At 8:00 p.m. the machine could not give a number and only read as "HI". On 9/19/13 at 0010 (12:10 a.m.) the blood sugar was 515. On 9/19/13, at 7:00 a.m., the final recorded blood sugar for R300 was 524. Review of the interdisciplinary notes included the following: A note written by registered nurse (RN)-E on 9/19/13, at 12:39 a.m. identified R300 had a blood glucose level of "HI" reading on 9/18/13, at 8:00 p.m. A call was placed to the on-call physician and orders were given to administer eight units of Novolog and fax the primary physician in the morning to obtain sliding scale parameters for R300's 8:00 p.m. blood sugars. A note written by licensed practical nurse (LPN)-C	F 157	5. All new admission Diabetic residents were interviewed to determine known symptomology of hypo/hyperglycemia and care plans were updated. (Implemented 1/26/14). 6. Ongoing chart audits to include: *Diabetic residents with glucometer checks *Change of Condition/Physician Notification. Medical Records Consultant and Pharmacy Consultant were updated on areas of focus. 7. Will continue to interview all new admission diabetic residents with glucometer checks to determine known symptomology of hyper/hypoglycemia and care plans will be updated.	

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F 157	Continued From page 4 on 9/19/13, at 10:44 a.m. indicated R300 had been nauseous and was dry heaving that day with a temperature of 100.2. A note written by LPN-C on 9/19/13, at 2:01 p.m. indicated staff had entered R300's room at 11:00 a.m. for therapy, when R300 was found unresponsive. Nursing staff lowered R300 to the ground, cardiopulmonary resuscitation (CPR) was initiated at 11:04 a.m. and continued until paramedics arrived. Per the time line that was provided by the facility, on the morning of 9/19/13, R300 awoke at her normal time, was alert and responding to staff by nodding yes or no. Blood sugar was checked at 0700 and was 524. Resident was given eight units of Novolog per insulin sliding scale and 20 units of Lantus. R300 went to breakfast and ate bites of toast and cereal. She was given two units of Novolog per carbohydrate counting orders. R300 participated in therapy from 9:30 to 9:55 a.m. and was brought back to her room. Per the nursing note written on 9/19/13, at 10:44 a.m., R300 was nauseated and dry heaving. R300 was left in her room and in her wheelchair. The desk nurse called the primary physician at 10:45 for a second attempt to follow up from the morning fax. A message was left with the primary's nurse. At 11:00 R300 was found unresponsive in her wheelchair. Staff began CPR and the desk nurse called 911 and then the primary physician was called again and was not available. A message was left again with the primary physician's nurse. Review of R300's code blue record (no date), revealed CPR was discontinued by the paramedics at 11:24 a.m. after a shock was	F 157	8. Licensed nursing staff will continue to contact the physicians of new admissions who are diabetic with glucometer checks and request when the physician wants to be notified of low or high blood sugars. 9. Pertinent data collected will be presented to the QI Committee and recommendations will be acted upon. 10. The Director of Nursing will be responsible to monitor for continued compliance. Completed by 2/14/14	

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F 157	Continued From page 5 administered and a pulse was found. The paramedics inserted a breathing tube and set up an external pacemaker and at 11:34 a.m. R300 was transported to the emergency room. R300 passed away in the emergency room on 9/19/13, at 12:55 p.m. Review of the facility's glucometer (Assure 4) manufacturer's manual dated 4/07 revealed a reading of "HI" meant the blood sugar test result was greater than 550 mg/dL and recommended seeking immediate medical assistance. An interview with LPN-F on 1/23/14, at 11:35 a.m. indicated that each resident had their own glucometer and LPN-F was not sure how high the machine reads. LPN-F also indicated that each resident had their own specific guidelines under the sliding scale order on when to call the physician. LPN-F was not sure of any facility policy of when to call the physician when the blood sugar was high. During interview on 1/23/14, at 12:04 p.m., RN-D indicated the facility supplied individual glucometers for residents when they were admitted which were all the same model. RN-D stated if a resident's blood sugar usually ran in the 100-200's and then was having readings in the 300-400 range, the staff would call the physician because that would be a change for the resident. RN-D also stated if the glucometer reading was too high to register on the machine a call would also be placed to the physician. RN-D further described how the physician would usually give an order for Insulin administration and that the staff should recheck the blood sugar after an hour, because Insulin is pretty fast acting. RN-D also suggested the staff should be rechecking the blood sugar hourly until it returned to a safe level.	F 157		

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F 157	Continued From page 6 During interview on 1/24/14, at 10:10 a.m., the director of nursing (DON) indicated she had completed an internal quality investigation of R300's incident days following the incident. However, DON stated she wasn't sure if the information gathered had been brought to the quality assurance meetings or not. DON revealed that the staff were not educated by the facility on specific parameters on when to call the physician related to blood sugar readings and felt the staff didn't need to call R300's physician when her readings were in the 500's because, "That was her baseline." DON also indicated no reeducation or changes of policy were completed after the investigation because it was felt the staff acted appropriately. On 1/24/14, at approximately 3:10 p.m., the DON verified there was no physician involvement in the internal quality investigation. R300's medical record lacked evidence of physician notification or involvement from 8:00 p.m. on 9/18/13, until the day shift of 9/19/13, despite her blood sugars having remained elevated (based on a blood sugar reading of 515 on 9/19/13, at 12:10 a.m. post administration of fast acting insulin). The medical record lacked evidence of on-going blood sugar testing throughout the overnight hours to ensure it returned to a safe level and lacked evidence considering the impact of R300's continuous tube feeding on her elevated blood sugars. The medical record also lacked evidence to support R300's baseline blood sugars were near 500 mg/dl. During interview on 1/24/14, at 1:03 p.m., licensed practical nurse (LPN)-C recalled caring	F 157		

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F 157	Continued From page 7	F 157		

for R300 during the morning 9/19/13, when she passed away. LPN-C stated R300's blood sugar had been high that morning and a fax was sent to the primary physician around 7:30 or 8:00 a.m., but she knew that the physician only worked a couple days a week and would be difficult to get a hold of. LPN-C indicated R300 had gone for therapy after breakfast, so no blood sugar recheck was completed. LPN-C was not aware of any facility policy which gave guidance on when to call a physician related to blood sugar results.

During interview on 1/24/14, at 1:18 p.m., medical doctor (MD)-A stated the expectation was that nurses would use their judgment on when to call a physician for high or low blood sugars. Further, MD-A indicated the nurses should recheck blood sugars to make sure they were responding and coming down and contacting a primary physician as soon as possible. However, if they couldn't get a hold of the physician, they could always send a resident to the hospital.

During interview on 1/27/14, at 8:11 a.m., MD-B stated it was his opinion that blood sugar readings greater than 500 were bad no matter what. MD-B indicated it was expected that if a resident had a blood sugar that high (greater than 500), the on-call physician should have been notified and an order for short acting insulin should have been given. The staff should have rechecked the blood sugar again after a few hours and notified the on-call physician again if still elevated. MD-B stated type one diabetics are at risk for decay and going into an acidotic state with blood sugars reading over 500. MD-B was unable to recall R300's specific baseline but stated that less than 200 would have been normal and acceptable. MD-B added that a person would

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F 157	Continued From page 8	F 157		

be in danger with blood sugars greater than 500 even if they didn't have any symptoms and that leaving someone with blood sugars that high can make it very difficult to get them normalized again, "It is a slippery slope."

During interview on 1/27/14, at 2:16 p.m., RN-E recalled being the nurse assigned to care for R300 on the night shift from 9/18/13-9/19/13. RN-E stated she would give the nursing assistants (NA) who she was working with a verbal report of anything pertinent about the residents. RN-E remembered that R300 had unstable blood sugars and had been on an insulin drip while hospitalized. RN-E also stated R300 was receiving tube feedings during the night which affected blood sugar readings, so the nurses had to take that into consideration when taking blood sugars and administering insulin. RN-E indicated R300's blood sugar had read "HI" on the evening of 9/18/13, so she called the on-call physician who gave instructions to administer the eight units of insulin for a blood sugar greater than 400 per R300's orders and to contact the primary physician in the morning to get parameters for the bedtime sliding scale. RN-E stated she then watched for symptoms of hyperglycemia (high blood sugar), and rechecked R300's blood sugar at on 9/19/13, at 12:10 a.m., per her nursing judgment. R300's blood sugar was 515. RN-E indicated she was aware 515 was an elevated result for R300 but did not think she needed to contact the on-call physician again because R300 did not have any symptoms of hyperglycemia. RN-E confirmed R300 had received her continuous tube feeding that night from 6:00 p.m. to 6:00 a.m.

Review of R300's vital sign record revealed the

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F 157	Continued From page 9 last set of vital signs checked were on 9/18/13 at 8:00 p.m. The abnormal vitals included a temperature of 99.2 and a rapid pulse at 116. No vital signs were checked again until R300 was found unresponsive. During interview on 1/27/14, at 11:26 a.m., NA-B didn't think the nurses usually passed on information to the nursing assistants about a resident having high blood sugars, that information was usually just between the nurses, but the nurses would tell them to be aware of the signs of high or low blood sugars. NA-B recalled working the night shift on 9/18/13-9/19/13 with R300 and stated the nurse had not passed on any specific information to be aware of, such as monitoring for signs of hyperglycemia when caring for R300 that night. During interview on 1/28/14, at 8:21 a.m., MD-C stated it was expected that the nurses recheck a blood sugar after administration of short acting insulin and call the on call physician again if the blood sugar remained elevated. MD-C indicated elevated was considered when the machine read "HI" for sure, but also greater than 400. MD-C didn't think anyone would not call if the level stayed elevated as it was normal nursing judgment to call again and they wouldn't want that liability. MD-C confirmed a reading greater than 500 on a recheck warranted physician notification for sure and potential dangers for type one diabetics with blood sugars that high included decay which was the most obvious. Review of the facility's policy titled, Treatment for Diabetic Residents which was last reviewed on 7/10, gave direction to observe for and report immediately symptoms of hyperglycemia such as	F 157		

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F 157	Continued From page 10 restlessness, tachycardia and nausea and/or vomiting. Review of the facility's policy titled, Change in Condition which was last reviewed in 4/08 revealed licensed staff would obtain necessary data for a complete assessment and notify the physician of the change. The policy further gave direction that if unable to contact the physician after 1/2 to four hours, depending on the significance of change, to contact the medical director. Also, follow up by the licensed staff of the change in condition should continue for a minimum of 48 hours following the onset of the change which is to include at a minimum a full set of vital signs every four hours for the first 24 hours. A policy specifically related to the treatment of hyperglycemia was requested however, per the DON on 1/28/14, at 2:33 p.m., no such policy existed as the medical director was more concerned about hypoglycemia and reluctant to specify parameters for treatment of hyperglycemia. The immediate jeopardy that began on 9/19/13, was removed on 1/28/14, at 3:15 p.m. when the facility implemented a corrective action plan which included: -On 1/27/14, facility staff contacted the physicians of residents who are diabetic and determined when the physician should be notified of low or high blood sugar readings. - On 1/25/14, the facility staff audited all charts of residents that were diabetic, and reviewed for change of condition and notification to the physician. -All licensed staff were educated on signs and	F 157		

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F 157	Continued From page 11 symptoms of hyper/hypoglycemia and normal lab values by 1/28/14. -On 1/26/14, Policies and procedures were updated for standard practice of when to notify the physician for change of status and policies and procedures for diabetes and staff were educated on the updates by 1/28/14. The corrective action plan was verified through record review, observation and staff interview. The IJ was removed but non compliance remained at the lower scope and severity level of a G (actual harm that is not immediate jeopardy). R355 experienced a change of condition related to atypical blood glucose levels; however, the facility failed to notify his physician of the change. R355's History and Physical dated 1/4/14, revealed evidence of mild acute kidney injury with a creatinine level of 1.36 mg/dL (with a baseline of 1.16 mg/dL). The report also noted a blood glucose of 117 mg/dL (with a normal range of 70 to 100 mg/dL), with a plan to hold metformin (an oral agent used to manage blood sugars) due to concerns of renal insufficiency. Review of the hospital medication administration report dated 1/1/14 through 1/7/14, revealed R355 received insulin to manage his blood sugars while hospitalized. R355 received the following: Novolog Flexpen 100 units/ milliliter (U/mL) insulin pen, correction scale, daily at bedtime, starting 1/4/14, through discharge from the hospital on 1/7/14. Novolog Flexpen 100 U/mL insulin pen, correction scale, three times daily, starting 1/5/14, through discharge from the hospital on 1/7/14.	F 157		

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F 157	Continued From page 12 The Safe Transitions of Care Transfer Form dated 1/7/14, identified R355 with controlled type-two diabetes, alert/oriented mental status, and hospitalization post right ankle sprain with discharge goals of continuing rehabilitation. R355's Orders Discharge Report dated 1/7/14, included a diabetic and cardiac diet, with metformin 500 mg noted as ON HOLD until his creatinine levels returned to baseline. The orders identified R355's usual dose of metformin was 500 mg, three times daily. The orders did not include insulin as was administered during his hospital stay. The orders lacked an individualized goal range for blood sugars, or parameters for when his physician was to be notified. Subsequent physician orders for R355 included the following: On 1/8/14, at 4:00 a.m. an order from the nurse practitioner was received for glucometer checks, twice daily at alternate times, lab draw for hemoglobin A1C (a lab test used to gauge how well blood sugars were controlled over time), and metformin to remain on hold until R355's creatinine and A1C results were completed. On 1/9/14, a faxed request for physician orders requested a review of R355's labs and direction for his metformin having been on hold due to creatinine levels, noting his previous orders were for 500 mg three times daily. The physician's response was to continue with metformin on hold, re-check creatinine levels in one month and re-check hemoglobin A1C levels in one month. Review of Interdisciplinary Notes for R355 from 1/7/14 through 1/24/14, revealed the following: On 1/8/14, at 3:52 p.m. licensed practical nurse (LPN)-D noted that R355 was to have labs drawn	F 157		

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F 157	Continued From page 13 the following day to determine whether metformin was to be restarted. On 1/9/14, at 12:47 p.m. LPN-D noted R355's labs were reviewed by the nurse practitioner and metformin was to continue to be on hold, with a redraw of his hemoglobin A1C in one month. Review of Glucometer Record dated 1/8/14 through 1/25/14, revealed blood sugar readings ranging from 116 to 364 mg/dL. The 8:00 p.m. blood sugar readings revealed a progressive increase, including readings of 246, 270, 268, 290, 249, 292, 306, and 364. R355 had three readings above 300, including a reading of 349 on 1/21/14, at 11:00 a.m. (prior to eating lunch), with the following reading of 306 at 8:00 p.m., and a reading of 364 on 1/23/14, at 8:00 p.m. R355's medical record revealed physician visits took place on 1/13/14, and as recently as 1/24/14, but lacked evidence to indicate his blood sugars were addressed and/or reviewed during these visits. During interview on 1/25/14, at 10:10 a.m. R355 reported he was unsure of the signs and symptoms his body tended to present when his blood sugars were high. R355 stated that prior to his hospitalization he lived alone at home, with well controlled blood sugars which ran between 90 to 110 mg/dL. R355 denied any symptoms of hyperglycemia. During interview on 1/24/14, at 7:52 a.m. LPN-E stated she would have notified a resident's physician for blood sugars outside of the physician ordered parameters. She stated that if no parameters were identified, she would still notify the physician if the blood sugar was outside	F 157		

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F 157	Continued From page 14 of the resident's typical range. During interview on 1/27/14, at 1:50 p.m. registered nurse (RN)-C stated she would monitor a resident for signs or symptoms of hyperglycemia and review the resident's diet if she noticed a gradual increase of blood sugars at a specified time of day. When asked specifically about R355's progressive increase of his 8:00 p.m. blood sugars, RN-C stated that the facility staff were paying attention to R355's blood sugars and were looking at his diet. She added, R355 felt fine and was asymptomatic. RN-C stated that R355's doctor rounded in the facility on a daily basis and concerns such as this were noted for them to review during rounds. She reported that the physician was notified of R355's increasing blood sugars during rounds on the afternoon of 1/25/14, and the metformin was ordered to be restarted in response. RN-C stated that if his blood sugars had "jumped" higher and he was symptomatic, the change of condition would have been handled with more urgency.	F 157		
F 161 SS=E	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure surety bond coverage equal to the actual resident funds account balance. This had the potential to affect 96 of	F 161	Plan of Correction F161 1) The Surety Bond was adjusted on 1/30/2014 to cover the value of the balances held currently in the resident trust account.	

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F 161	Continued From page 15 150 residents who had their funds managed by the facility. Findings include: During an interview on 1/27/14, at 10:14 a.m., the facility controller (CT) stated he thought the surety bond was short of the actual resident accounts balance. He verified the resident accounts balance as of 9/30/13, was $54,707.62. The most recent balance in the accounts as of 12/30/13 was $44,496.33. The CT reviewed the surety bond held by the facility, dated 1/27/14. The surety bond covered total funds of $23,000. During an interview on 1/27/14, at 10:16 a.m. the CT was asked about the facility policy for comparing the surety bond coverage against the resident accounts balance. The CT indicated it was their responsibility and had placed a call today to their insurance agency to increase the value of the surety bond. The CT said the increase in coverage would take two days to complete, and that he reviewed the coverage yearly, usually in February or March but did it "a little early" this year. The facility's policy entitled Surety Bonds, dated 5/12/09, indicated the facility was obligated to insure the value of the monies held in the resident trust account against potential loss or theft, and would carry a surety bond to cover the value of the balances held in the resident trust account.	F 161	2) The Surety Bond procedure was updated to include a review of the General Ledger balance of the Resident Trust Account on a monthly basis and initiate required adjustments to the Surety Bond to assure proper security for these funds. 3. A monthly audit tool was developed and implemented by the CFO to assure continued compliance. Completion date: 1/30/2014 Chief Financial Officer will be responsible for assuring continued compliance.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have	F 225		

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F 225	Continued From page 16 been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an instance of significantly	F 225	Plan of Correction F225 1. Nursing staff were re-educated on the Minnesota Vulnerable Adult Act, reporting instances of abuse, neglect and/or mistreatment and on the implementation of abuse prohibition policies related to immediate reporting to the state agency. 2. All staff will be given the Minnesota Vulnerable Adult Act educational brochure with paychecks on 2/28/14.	

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F 225	Continued From page 17 elevated blood sugars without prompt notification to the physician for further instruction, was identified as potential neglect of medical care and immediately reported to the state agency (SA), for 1 of 1 residents (R300) reviewed for neglect of care. Findings include: R300 was admitted to the facility after a hospitalization for acute renal failure, diabetic ketoacidosis (a life-threatening complication when the body does not produce enough insulin), and a brain aneurysm with ventriculoperitoneal shunt placement. While hospitalized, R300 had blood sugars greater than 1,100 milligrams per deciliter (mg/dL) which required a continuous insulin drip to return to normal levels. The admission Minimum Data Set (MDS) completed on 9/23/13, identified R300's cognitive skills for decision making were severely impaired, she did not speak and was rarely understood. Review of R300's glucometer record included the following blood sugar results: From 9/10/13, to 9/17/13, the results ranged from 71-386 with one reading of 409. On 9/18/13, at 7:00 a.m. the blood sugar was 392. At 11:00 a.m. it was 525. At 8:00 p.m. the machine could not give a number and only read as "HI". On 9/19/13, at 12:10 a.m. R300's blood sugar was 515. At 7:00 a.m., the final recorded blood sugar for R300 was 524. Review of the facility's glucometer manufacturer's manual dated 4/07, revealed a reading of "HI" meant the blood sugar test result was greater than 550 mg/dL and recommended seeking immediate medical assistance.	F 225	3. The all staff Mandatory In-service to be conducted tentavely April 8 and 9 2014 will re-educate staff on the Minnesota Vulnerable Adult Act, reporting instances of abuse, neglect and/or mistreatment and on the implementation of abuse prohibition policies related to immediate reporting to the state agency. 4. Director of Social Service will be responsible for assuring continued compliance and will submit pertinent findings to QI for review. Completed by 2/28/14	

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F 225	Continued From page 18 Review of the interdisciplinary notes included the following: A note written by registered nurse (RN)-E on 9/19/13, at 12:39 a.m. identified R300 had a blood glucose level of "HI" reading on 9/18/13, at 8:00 p.m. A call was placed to the on-call physician and orders were given to administer eight units of Novolog and fax the primary physician in the morning to obtain sliding scale parameters for R300's 8:00 p.m. blood sugars. A note written by licensed practical nurse (LPN)-C on 9/19/13, at 10:44 a.m. indicated R300 had been nauseous and was dry heaving that day with a temperature of 100.2. A note written by LPN-C on 9/19/13, at 2:01 p.m. indicated staff had entered R300's room at 11:00 a.m. for therapy, when R300 was found unresponsive. Nursing staff lowered R300 to the ground, cardiopulmonary resuscitation (CPR) was initiated at 11:04 a.m. and continued until paramedics arrived. During interview on 1/23/14, at 12:04 p.m. RN-D stated if a resident's blood sugar usually ran in the 100-200's and then was having readings in the 300-400 range, the staff should have called the physician because that would be a change for the resident. RN-D also stated if the glucometer reading was too high to register on the machine a call would also be placed to the physician. RN-D further described how the physician would usually give an order for insulin administration and that the staff should have rechecked the blood sugar after an hour, because insulin was fast acting. RN-D also suggested the staff should have rechecked the blood sugar hourly until it returned	F 225		

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F 225	Continued From page 19 to a safe level. During interview on 1/24/14, at 10:10 a.m., the director of nursing (DON) indicated she had completed an internal quality investigation of R300's incident, days after the incident occurred. DON revealed that the staff were not educated by the facility on specific parameters for when to call the physician related to blood sugar readings and felt the staff did not need to call R300's physician when her readings were in the 500's because, "That was her baseline." DON also indicated no re-education or changes of policy were completed after the investigation because it was felt the staff acted appropriately. R300's medical record lacked evidence of physician notification or involvement from 8:00 p.m. on 9/18/13, until the day shift of 9/19/13, despite her blood sugars having remained elevated (based on a blood sugar reading of 515 on 9/19/13, at 12:10 a.m. post administration of fast acting insulin). The medical record lacked evidence of on-going blood sugar testing throughout the overnight hours to ensure it returned to a safe level and lacked evidence considering the impact of R300's continuous tube feeding on her elevated blood sugars. The medical record also lacked evidence to support R300's baseline blood sugars were near 500 mg/dL. During a telephone conference with the State Agency (SA) on 1/24/14, at 5:25 p.m. vice president of long-term care (VP) reported that the facility had investigated the events preceding the death of R300 to determine whether there may have been neglect, but determined no neglect had occurred and therefore, no report was	F 225		

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F 225	Continued From page 20 submitted to the state agency. During interview on 1/27/14, at 1:42 p.m. DON indicated that any instance of not following a resident's care plan that could have potentially resulted in harm to a resident was reportable to the SA. The DON confirmed the events preceding the death of R300 were investigated by the facility because facility staff performed CPR on R300 and it was standard practice for the facility to investigate such incidents to evaluate whether appropriate care was provided and whether further reporting was necessary due to potential neglect. The DON stated, "[R300] was up for breakfast... asymptomatic... we didn't feel it was reportable." The DON added, "I didn't even feel like it was [potential neglect]... I'm still wondering what it would have been that would have been reportable." At 2:05 p.m., the DON reported that she intended to report incidents such as this in the future, but she did not feel it was reportable. She added, "Otherwise I would have reported it." The facility's Vulnerable Adult Act Policies & Procedures revised 12/13, defined neglect as the failure of a caregiver to provide a resident with care or services, including health care or supervision which is reasonable and necessary to maintain the resident's physical health or safety. The procedure instructs employees to immediately report concerns of potential abuse, neglect or mistreatment to the SA.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		

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F 226	Continued From page 21	F 226		

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure abuse prohibition policies were implemented, related to the immediate reporting to the state agency (SA), an instance of significantly elevated blood sugars without prompt notification to the physician for further instruction, for 1 of 1 residents (R300) reviewed for neglect of care.
Findings include:
The facility's Vulnerable Adult Act Policies & Procedures revised 12/13, defined neglect as the failure of a caregiver to provide a resident with care or services, including health care or supervision which is reasonable and necessary to maintain the resident's physical health or safety. The procedure instructs employees to immediately report concerns of potential abuse, neglect or mistreatment to the SA.
R300 was admitted to the facility after a hospitalization for acute renal failure, diabetic ketoacidosis (a life-threatening complication when the body does not produce enough insulin), and a brain aneurysm with ventriculoperitoneal shunt placement. While hospitalized, R300 had blood sugars greater than 1,100 milligrams per deciliter (mg/dL) which required a continuous insulin drip to return to normal levels.

The admission Minimum Data Set (MDS) completed on 9/23/13, identified R300's cognitive skills for decision making were severely impaired, she did not speak and was rarely understood.

Review of R300's 9/13 glucometer record

Plan of Correction

F226

1. Nursing staff were re-educated on the Minnesota Vulnerable Adult Act, reporting instances of abuse, neglect and/or mistreatment and on the implementation of abuse prohibition policies related to immediate reporting to the state agency.

2. All staff will be given the Minnesota Vulnerable Adult Act educational brochure with paychecks on 2/28/14.

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F 226	Continued From page 22 included the following blood sugars: From 9/10/13, to 9/17/13, the results ranged from 71-386 with one reading of 409. On 9/18/13, at 7:00 a.m. the blood sugar was 392. At 11:00 a.m. it was 525. At 8:00 p.m., the machine could not give a number and only read as "HI". On 9/19/13, at 12:10 a.m. R300's blood sugar was 515. At 7:00 a.m., the final recorded blood sugar for R300 was 524. Review of the facility's glucometer manufacturer's manual dated 4/07, revealed a reading of "HI" meant the blood sugar test result was greater than 550 mg/dL and recommended seeking immediate medical assistance. Review of the interdisciplinary notes included the following: A note written by registered nurse (RN)-E on 9/19/13, at 12:39 a.m. identified R300 had a blood glucose level of "HI" reading on 9/18/13, at 8:00 p.m. A call was placed to the on-call physician and orders were given to administer eight units of Novolog and fax the primary physician in the morning to obtain sliding scale parameters for R300's 8:00 p.m. blood sugars. A note written by licensed practical nurse (LPN)-C on 9/19/13, at 10:44 a.m. indicated R300 had been nauseous and was dry heaving that day with a temperature of 100.2. A note written by LPN-C on 9/19/13, at 2:01 p.m. indicated staff had entered R300's room at 11:00 a.m. for therapy, when R300 was found unresponsive. Nursing staff lowered R300 to the ground, cardiopulmonary resuscitation (CPR) was initiated at 11:04 a.m. and continued until	F 226	3. The all staff Mandatory In-service to be conducted tentavely April 8 and 9 2014 will re-educate staff on the Minnesota Vulnerable Adult Act, reporting instances of abuse, neglect and/or mistreatment and on the implementation of abuse prohibition policies related to immediate reporting to the state agency. 4. Director of Social Service will be responsible for assuring continued compliance and will submit pertinent findings to QI for review. Completed by 2/28/14	

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F 226	Continued From page 23 paramedics arrived. During interview on 1/23/14, at 12:04 p.m. RN-D stated if a resident's blood sugar usually ran in the 100-200's and then was having readings in the 300-400 range, the staff should have called the physician because that would be a change for the resident. RN-D also stated if the glucometer reading was too high to register on the machine a call would also be placed to the physician. RN-D further described how the physician would usually give an order for insulin administration and that the staff should have rechecked the blood sugar after an hour, because insulin was fast acting. RN-D also suggested the staff should have rechecked the blood sugar hourly until it returned to a safe level. During interview on 1/24/14, at 10:10 a.m., the director of nursing (DON) indicated she had completed an internal quality investigation of R300's incident, days after the incident. DON revealed that the staff were not educated by the facility on specific parameters for when to call the physician related to blood sugar readings and felt the staff did not need to call R300's physician when her readings were in the 500's because, "That was her baseline." DON also indicated no re-education or changes of policy were completed after the investigation because it was felt the staff acted appropriately. R300's medical record lacked evidence of physician notification or involvement from 8:00 p.m. on 9/18/13, until the day shift of 9/19/13, despite her blood sugars having remained elevated (based on a blood sugar reading of 515 on 9/19/13, at 12:10 a.m. post administration of fast acting insulin). The medical record lacked	F 226		

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F 226	Continued From page 24 evidence of on-going blood sugar testing throughout the overnight hours to ensure it returned to a safe level and lacked evidence considering the impact of R300's continuous tube feeding on her elevated blood sugars. The medical record also lacked evidence to support R300's baseline blood sugars were near 500 mg/dL. During a telephone conference with the State Agency (SA) on 1/24/14, at 5:25 p.m. vice president of long-term care (VP) reported that the facility had investigated the events preceding the death of R300 to determine whether there may have been neglect, but determined no neglect had occurred, therefore, no report was submitted to the SA. During interview on 1/27/14, at 1:42 p.m. DON indicated that any instance of not following a resident's care plan that could have potentially resulted in harm to a resident was reportable to the SA. The DON confirmed the events preceding the death of R300 were investigated by the facility because facility staff performed CPR on R300 and it was standard practice for the facility to investigate such incidents to evaluate whether appropriate care was provided and whether further reporting was necessary due to potential neglect. The DON stated, "[R300] was up for breakfast... asymptomatic... we didn't feel it was reportable." The DON added, "I didn't even feel like it was [potential neglect]... I'm still wondering what it would have been that would have been reportable." At 2:05 p.m., the DON reported that she intended to report incidents such as this in the future, but she did not feel it was reportable. She added, "Otherwise I would have reported it."	F 226		

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F 309	Continued From page 25	F 309		
F 309 SS=K	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure changes in clinical status, including significantly elevated blood sugar levels, were clinically monitored and promptly reported to the physician for 2 of 28 residents (R300, R355) with diabetes. The lack of clinical monitoring and failure to notify the physician resulted in an immediate jeopardy situation with the potential to affect 53 diabetic residents who required blood glucose monitoring. This resulted in actual harm for R300 who required emergency medical interventions on 9/19/13, and expired. The facility also failed to administer as needed insulin per parameters identified in the physician orders for 1 of 28 residents (R69) with diabetes. The immediate jeopardy began on 9/19/13, when the facility failed to promptly notify the physician of elevated blood sugars and was identified on 1/24/14. The director of nursing (DON), vice president of long term care and rehab (rehabilitation) operations, and director of rehab were notified of the immediate jeopardy on 1/24/14, at 4:32 p.m. The immediate jeopardy was removed on 1/28/14, at 3:15 p.m. but non	F 309	Plan of Correction F309 1. Licensed nursing staff contacted physicians of residents who are diabetic with glucometer checks and requested when the physician wanted to be notified of low or high blood sugars. (Implemented 1/27/14). 2. Licensed nursing staff audited all diabetic resident charts and reviewed for change of condition and physician notification. (Implemented 1/25/14). 3. Licensed nursing staff were re-educated on signs and symptoms of hyper/hypoglycemia and normal lab values. (Implemented 1/28/14).	

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F 309	Continued From page 26 compliance remained at the lower scope and severity level of a G (actual harm that is not immediate jeopardy). Findings include: R300 was admitted to the facility on 9/10/13, after a hospitalization for acute renal failure, diabetic ketoacidosis (a life-threatening complication when the body does not produce enough insulin), and a brain aneurysm with ventriculoperitoneal shunt (used to take excess fluid from brain, and "shunt" or divert it to the abdomen for absorption) placement. While hospitalized, R300 had blood sugars greater than 1,100 milligrams per deciliter (mg/dL) which required a continuous insulin drip to return to normal levels. R300 diagnoses per the hospital discharge summary dated 9/10/13, included but were not limited to Type 1 diabetes, hypertension and stroke. The admission Minimum Data Set (MDS) completed on 9/23/13 identified R300's cognitive skills for decision making were severely impaired, that the resident did not speak, and that a brief interview for mental status (BIMS) was not completed because R300 was rarely understood. R300's physician orders from the September 2013 medication administration record included: Novolog (a quick acting insulin) one unit per carbohydrate consumed with each meal Novolog sliding scale insulin with all meals per blood sugar results Lantus (a long acting insulin) 20 units with breakfast and at bedtime Glucometer (blood sugar) checks four times a day Ensure Clear (a nutritional supplement) 120	F 309	4. The Diabetic Policy and Change of Condition Policy were updated to include the following for diabetic residents with glucometer checks: *The physician will be contacted and asked to identify parameters for physician notification on new diabetic admissions who receive glucometer checks. *New admissions with diabetes will be asked if they can tell when their blood sugar is high or low and the information will be documented. The above policy was reviewed and approved by the Medical Director. Licensed nursing staff was re-educated on the updated Diabetic and Change of Condition Policies. (1/28/14)	

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F 309	Continued From page 27 milliliters (mL) four times a day Osmolite (liquid nutrition) 1.5 mL/hour for nine hours at night via enteral tube (feeding tube) Review of R300's September 2013 glucometer records included the following the following documented blood sugars (BS): From 9/10/13, to 9/17/13, the BS results ranged from 71-386 with one reading of 409. On 9/18/13, at 7:00 a.m., the blood sugar was 392. At 11:00 a.m. it was 525. At 8:00 p.m. the BS reading recorded as "HI". On 9/19/13 at 0010 (12:10 a.m.) the blood sugar was 515. On 9/19/13, at 7:00 a.m., the final recorded blood sugar for R300 was 524. Review of the interdisciplinary notes included the following: A note written by registered nurse (RN)-E on 9/19/13, at 12:39 a.m. identified R300 had a blood glucose level of "HI" on 9/18/13, at 8:00 p.m. A call was placed to the on-call physician and orders were given to administer eight units of Novolog and fax the primary physician in the morning to obtain sliding scale parameters for R300's 8:00 p.m. blood sugars. A note written by licensed practical nurse (LPN)-C on 9/19/13, at 10:44 a.m. indicated R300 had been nauseated and was dry heaving that day with a temperature of 100.2° Fahrenheit(F) and a call was placed to the primary medical physician and message was left with the physician's nurse. A note written by LPN-C on 9/19/13, at 2:01 p.m. indicated staff had entered R300's room at 11:00 a.m. for therapy, when R300 was found unresponsive. Nursing staff lowered R300 to the	F 309	5. All new admission Diabetic residents were interviewed to determine known symptomology of hypo/hyperglycemia and care plans were updated. (Implemented 1/26/14). 6. Ongoing chart audits to include: *Diabetic residents with glucometer checks *Change of Condition/Physician Notification. Medical Records Consultant and Pharmacy Consultant were updated on areas of focus. 7. Will continue to interview all new admission diabetic residents with glucometer checks to determine known symptomology of hyper/hypoglycemia and care plans will be updated.	

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F 309	Continued From page 28 ground, cardiopulmonary resuscitation (CPR) was initiated at 11:04 a.m. and continued until paramedics arrived. Per the time line that was provided by the facility, on the morning of 9/19/13, R300 awoke at her normal time, was alert and responding to staff by nodding yes or no. Blood sugar was checked at 0700 and was 524. Resident was given eight units of Novolog per insulin sliding scale and 20 units of Lantus. R300 went to breakfast and ate bites of toast and cereal. She was given two units of Novolog per carbohydrate counting orders. R300 participated in therapy from 9:30 to 9:55 a.m. and was brought back to her room. Per the nursing note written on 9/19/13 at 10:44 a.m., R300 was nauseated and dry heaving. R300 was left in her room and in her wheelchair. The desk nurse called the primary physician at 10:45 a.m. for a second attempt to follow up from the morning fax. A message was left with the primary's nurse. At 11:00 a.m. R300 was found unresponsive in her wheelchair. Staff began CPR and the desk nurse called 911 and then the primary physician was called again but was not available. A message was left again with the primary physician's nurse. Review of R300's code blue record (no date), revealed CPR was discontinued by the paramedics at 11:24 a.m. after a shock was administered and a pulse was found. The paramedics inserted a breathing tube and set up an external pacemaker and at 11:34 a.m. R300 was transported to the emergency room. R300 passed away in the emergency room on 9/19/13, at 12:55 p.m. Review of the facility's glucometer (Assure 4)	F 30	8. Licensed nursing staff will continue to contact the physicians of new admissions who are diabetic with glucometer checks and request when the physician wants to be notified of low or high blood sugars. 9. Pertinent data collected will be presented to the QI Committee and recommendations will be acted upon. 10. The Director of Nursing will be responsible to monitor for continued compliance. Completed by 2/14/14	

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manufacturer's manual dated 4/07 revealed a reading of "HI" meant the blood sugar test result was greater than 550 mg/dL and recommended seeking immediate medical assistance. An interview with LPN-F on 1/23/14, at 11:35 a.m. indicated that each resident had their own glucometer and LPN-F was not sure how high the machine read. LPN-F also indicated that each resident had their own specific guidelines under a sliding scale order on when to call the physician. LPN-F was not sure of any facility policy of when to call the physician when a resident's blood sugar was high.

During interview on 1/23/14, at 12:04 p.m., RN-D indicated the facility supplied individual glucometers for residents when they were admitted which were all the same model. RN-D stated if a resident's blood sugar usually ran in the 100-200's and then was having readings in the 300-400 range, the staff would call the physician because that would be a change for the resident. RN-D also stated if the glucometer reading was too high to register on the machine a call would also be placed to the physician. RN-D further described how the physician would usually give an order for insulin administration and that the staff should recheck the blood sugar after an hour, because insulin is pretty fast acting. RN-D also suggested the staff should be rechecking the blood sugar hourly until it returned to a safe level.

During interview on 1/24/14, at 10:10 a.m., the DON indicated she had completed an internal quality investigation of R300's incident days following the incident. However, DON stated she wasn't sure if the information gathered had been brought to the quality assurance meetings or not. The DON stated the staff were not educated by

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the facility on specific parameters on when to call the physician related to blood sugar readings and felt the staff didn't need to call R300's physician when her readings were in the 500's because, "That was her baseline." The DON also indicated no reeducation or changes of policy were completed after the investigation because it was felt the staff had acted appropriately. On 1/24/14, at approximately 3:10 p.m., the DON verified there had been no physician involvement in the internal quality investigation.

R300's medical record lacked evidence of physician notification or involvement from 8:00 p.m. on 9/18/13, until the day shift of 9/19/13, despite her blood sugars having remained elevated (based on a blood sugar reading of 515 on 9/19/13, at 12:10 a.m. post administration of fast acting insulin). The medical record lacked evidence of on-going blood sugar testing throughout the overnight hours to ensure it returned to a safe level and lacked evidence considering the impact of R300's continuous tube feeding on her elevated blood sugars. The medical record also lacked evidence to support R300's baseline blood sugars having been near 500 mg/dl.

During interview on 1/24/14, at 1:03 p.m., licensed practical nurse (LPN)-C recalled caring for R300 during the morning 9/19/13, when R300 passed away. LPN-C stated R300's blood sugar had been high that morning and a fax had been sent to the primary physician around 7:30 or 8:00 a.m., but she knew that the physician only worked a couple days a week and would be difficult to get a hold of. LPN-C indicated R300 had gone for therapy after breakfast, so no blood sugar recheck had been completed. R300 returned

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F 309	Continued From page 31 from therapy and was brought back to her room because she had nausea. Staff left R300 up in her wheelchair because of the nausea. Staff found R300 in her room at 11:00 a.m. unresponsive. LPN-C was not aware of any facility policy which gave guidance on when to call a physician related to blood sugar results. During interview on 1/24/14, at 1:18 p.m., medical doctor (MD)-A stated the expectation was that nurses would use their judgment on when to call a physician for high or low blood sugars. Further, MD-A indicated the nurses should recheck blood sugars to make sure they were responding and coming down and contacting a primary physician as soon as possible. However, if they couldn't get a hold of the physician, they could always send a resident to the hospital. During interview on 1/27/14, at 8:11 a.m., MD-B stated it was his opinion that blood sugar readings greater than 500 were bad no matter what. MD-B stated it was expected that if a resident had a blood sugar that high (greater than 500), the on-call physician should have been notified and an order for short acting insulin should have been given. MD-B further stated the staff should have rechecked the blood sugar again after a few hours and notified the on-call physician again if still elevated. MD-B stated type one diabetics are at risk for decay and going into an acidotic state with blood sugars reading over 500. MD-B was unable to recall R300's specific baseline but stated that less than 200 would have been normal and acceptable. MD-B added that a person would be in danger with blood sugars greater than 500 even if they didn't have any symptoms and that leaving someone with blood sugars that high can make it very difficult to get	F 309		

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them normalized again stating, "It is a slippery slope."

During interview on 1/27/14, at 2:16 p.m., RN-E recalled being the nurse assigned to care for R300 on the night shift from 9/18/13-9/19/13. RN-E stated she would give the nursing assistants (NA) who she was working with a verbal report of anything pertinent about the residents. RN-E remembered that R300 had unstable blood sugars and had been on an insulin drip while hospitalized. RN-E also stated R300 was receiving tube feedings during the night which affected blood sugar readings, so the nurses had to take that into consideration when taking blood sugars and administering insulin. RN-E indicated R300's blood sugar had read "HI" on the evening of 9/18/13, so she had called the on-call physician who had given instructions to administer eight units of insulin for a blood sugar greater than 400 per R300's orders, and to contact the primary physician in the morning to get parameters for the bedtime sliding scale. RN-E stated she then watched for symptoms of hyperglycemia (high blood sugar), and rechecked R300's blood sugar on 9/19/13, at 12:10 a.m., per her nursing judgment. At that time R300's blood sugar was 515. RN-E indicated she was aware 515 was an elevated result for R300 but did not think she needed to contact the on-call physician again because R300 did not have any symptoms of hyperglycemia. RN-E confirmed R300 had received her continuous tube feeding that night from 6:00 p.m. to 6:00 a.m.

Review of R300's vital sign record revealed the last set of vital signs checked were on 9/18/13 at 8:00 p.m. At that time R300 had abnormal vital signs including a temperature of 99.2°F and a

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rapid pulse at 116. No vital signs had been checked again until R300 was found unresponsive the following morning.

During interview on 1/27/14, at 11:26 a.m., NA-B stated she didn't think the nurses usually passed on information to the nursing assistants about a resident having high blood sugars, and stated that information was usually just between the nurses, but the nurses would tell them to be aware of the signs of high or low blood sugars. NA-B recalled working the night shift on 9/18/13, through 9/19/13, with R300 and stated the nurse had not passed on any specific information to be aware of, such as monitoring for signs of hyperglycemia when caring for R300 that night.

During interview on 1/28/14, at 8:21 a.m., MD-C stated it was expected that the nurses recheck a blood sugar after administration of short acting insulin and call the on call physician again if the blood sugar remained elevated. MD-C indicated elevated was considered when the machine read "HI" for sure, but also greater than 400. MD-C didn't think anyone would not call if the level stayed elevated as it was normal nursing judgment to call again and they wouldn't want that liability. MD-C confirmed a reading greater than 500 on a recheck warranted physician notification for sure and potential dangers for type one diabetics with blood sugars that high included decay which was the most obvious.

Review of the facility's policy titled, Treatment for Diabetic Residents last reviewed 7/10, gave direction to observe for and report immediately symptoms of hyperglycemia such as restlessness, tachycardia and nausea and/or vomiting.

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F 309	Continued From page 34 Review of the facility's policy titled, Change in Condition last reviewed 4/08, revealed licensed staff were to obtain necessary data for a complete assessment and notify the physician of the change. The policy further gave direction that if unable to contact the physician after 1/2 to four hours, depending on the significance of change, to contact the medical director. Also, follow up by the licensed staff of the change in condition should continue for a minimum of 48 hours following the onset of the change which is to include at a minimum a full set of vital signs every four hours for the first 24 hours. A policy specifically related to the treatment of hyperglycemia was requested, however, the DON verified during interview on 1/28/14, at 2:33 p.m., no such policy existed as the medical director was more concerned about hypoglycemia and was reluctant to specify parameters for treatment of hyperglycemia. The immediate jeopardy that began on 9/19/13, was removed on 1/28/14, at 3:15 p.m. when the facility implemented a corrective action plan which included: -On 1/27/14, facility staff contacted the physicians of residents who are diabetic and determined when the physician should be notified of low or high blood sugar readings. - On 1/25/14, the facility staff audited all charts of residents that were diabetic, and reviewed for change of condition and notification to the physician. -All licensed staff were educated on signs and symptoms of hyper/hypoglycemia and normal lab values by 1/28/14. -On 1/26/14, Policies and procedures were	F 309		

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F 309	Continued From page 35 updated for standard practice of when to notify the physician for change of status and policies and procedures for diabetes and staff were educated on the updates by 1/28/14. The corrective action plan was verified through record review, observation and staff interview. The IJ was removed but non compliance remained at the lower scope and severity level of a G (actual harm that is not immediate jeopardy). R355's medical record lacked identification of rising blood glucose levels and/or evidence of physician notification of blood sugars outside of his typical range. The record also lacked evidence to support R355's diet was addressed in relation to his increased blood glucose levels. R355's History and Physical dated 1/4/14, revealed evidence of mild acute kidney injury with a creatinine level of 1.36 mg/dL (with a baseline of 1.16 mg/dL). The report also noted a blood glucose of 117 mg/dL (with a normal range of 70 to 100 mg/dL), with a plan to hold metformin (an oral agent used to manage blood sugars) due to concerns of renal insufficiency. Review of the hospital medication administration report dated 1/1/14 through 1/7/14, revealed R355 received insulin to manage his blood sugars while hospitalized. R355 received the following: Novolog Flexpen 100 units/ milliliter (U/mL) insulin pen, correction scale, daily at bedtime, starting 1/4/14, through discharge from the hospital on 1/7/14. Novolog Flexpen 100 U/mL insulin pen, correction scale, three times daily, starting 1/5/14, through discharge from the hospital on 1/7/14. The Safe Transitions of Care Transfer Form	F 309		

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F 309	Continued From page 36 dated 1/7/14, identified R355 with controlled type-two diabetes, alert/oriented mental status, and hospitalization post right ankle sprain with discharge goals of continuing rehabilitation. R355's Orders Discharge Report dated 1/7/14, included a diabetic and cardiac diet, with metformin 500 mg noted as ON HOLD until his creatinine levels returned to baseline. The orders identified R355's usual dose of metformin was 500 mg, three times daily. The orders did not include insulin as was administered during his hospital stay. The orders lacked an individualized goal range for blood sugars, or parameters for when his physician was to be notified. Subsequent physician orders for R355 included the following: On 1/8/14, at 4:00 a.m. an order from the nurse practitioner was received for glucometer checks, twice daily at alternate times, lab draw for hemoglobin A1C (a lab test used to gauge how well blood sugars were controlled over time), and metformin to remain on hold until R355's creatinine and A1C results were completed. On 1/9/14, a faxed request for physician orders requested a review of R355's labs and direction for his metformin having been on hold due to creatinine levels, noting his previous orders were for 500 mg three times daily. The physician's response was to continue with metformin on hold, re-check creatinine levels in one month and re-check hemoglobin A1C levels in one month. Review of Interdisciplinary Notes for R355 from 1/7/14 through 1/24/14, revealed the following: On 1/8/14, at 3:52 p.m. licensed practical nurse (LPN)-D noted that R355 was to have labs drawn the following day to determine whether metformin	F 309		

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was to be restarted.
On 1/9/14, at 12:47 p.m. LPN-D noted R355's labs were reviewed by the nurse practitioner and metformin was to continue to be on hold, with a redraw of his hemoglobin A1C in one month.

Review of Glucometer Record dated 1/8/14 through 1/25/14, revealed blood sugar readings ranging from 116 to 364 mg/dL. The 8:00 p.m. blood sugar readings revealed a progressive increase, including readings of 246, 270, 268, 290, 249, 292, 306, and 364. R355 had three readings above 300, including a reading of 349 on 1/21/14, at 11:00 a.m. (prior to eating lunch), with the following reading of 306 at 8:00 p.m., and a reading of 364 on 1/23/14, at 8:00 p.m.

R355's medical record revealed physician visits took place on 1/13/14, and as recently as 1/24/14, but lacked evidence to indicate his blood sugars were addressed and/or reviewed during these visits.

During interview on 1/25/14, at 10:10 a.m. R355 reported he was unsure of the signs and symptoms his body tended to present when his blood sugars were high. R355 stated that prior to his hospitalization he lived alone at home, with well controlled blood sugars which ran between 90 to 110 mg/dL. R355 denied any symptoms of hyperglycemia.

During interview on 1/24/14, at 7:52 a.m. LPN-E stated she would have notified a resident's physician for blood sugars outside of the physician ordered parameters. She stated that if no parameters were identified, she would still notify the physician if the blood sugar was outside of the resident's typical range.

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F 309	Continued From page 38 During interview on 1/27/14, at 1:50 p.m. registered nurse (RN)-C stated she would have monitored a resident for signs or symptoms of hyperglycemia and reviewed the resident's diet if she noticed a gradual increase of blood sugars at a specified time of day. When asked specifically about R355's progressive increase of his 8:00 p.m. blood sugars, RN-C stated that the facility staff were paying attention to R355's blood sugars and were looking at his diet. She added, R355 felt fine and was asymptomatic. RN-C stated that R355's doctor rounded in the facility on a daily basis and concerns such as this were noted for them to review during rounds. She reported that the physician was notified of R355's increasing blood sugars during rounds on the afternoon of 1/25/14, and the metformin was ordered to be restarted in response. RN-C stated that if his blood sugars had "jumped" higher and he was symptomatic, the change of condition would have been handled with more urgency. R69 did not receive insulin as ordered, for a blood sugar higher than 300. R69's significant change assessment MDS dated 10/30/13, included diagnosis of diabetes mellitus. R69's physician orders, dated 1/23/14, directed staff to give Lantus (long acting insulin given to treat diabetes) 26 units every morning, Lantus 30 units every evening, and Novolog (short acting insulin given to treat diabetes) 10 units for blood sugars greater than 300 mg/dl, as needed. No physician orders were found as to how often the staff should check R69's blood sugar, but the glucometer record indicated the staff were checking R69's blood sugars twice daily, at 7:00 a.m. and at 4:30 p.m. During a review of R69's glucometer record, LPN-B documented a blood sugar of 303 on	F 309		

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F 309	Continued From page 39 1/6/14, at 4:30 p.m. During a review of R69's Medication Record for January 2014, there is no evidence that Novolog insulin was given on 1/6/14, as ordered, for a blood sugar greater than 300 mg/dl. During a review of R69's Interdisciplinary Notes, there was no documentation to indicate why the Novolog insulin was not given as ordered for a blood sugar greater than 300 mg/dl. During an interview on 1/27/14, at 1:50 p.m., RN-C stated she would expect the staff to recheck the resident's blood sugar and if it was truly greater than 300, she would expect the staff to give the insulin as ordered. During an interview on 1/27/14, at 2:57 p.m., RN-A verified R69's blood sugar was 303 on 1/6/14, at 4:30 p.m., or just prior to eating supper, and verified that Novolog insulin was not given, as ordered, for blood sugar greater than 300. RN-A stated she did not know what the rationale was for not giving the insulin, adding, "Maybe the nurse talked to the supervisor." RN-A stated it was very unusual for R69 to have a blood sugar that high, and she would have had R69 eat supper and then rechecked the blood sugar, although RN-A acknowledged that R69's blood sugar would have gone higher after eating. RN-A indicated she was going to check with the supervisor that worked that evening, but "I would have liked to have seen that in the notes." At 3:10 p.m., RN-A stated she called LPN-B, and he reported he had consulted with the supervisor, RN-B, and was directed to not give the Novolog insulin because the blood sugar was so close to 300. During a telephone interview on 1/27/14, at 3:30 p.m., LPN-B stated he consulted with RN-B about R69's blood sugar of 303. LPN-B stated, "I felt bad poking her [R69]. I just decided to call the	F 309		

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F 309	Continued From page 40 supervisor." LPN-B stated RN-B directed him to not give the Novolog insulin, "because it was so close." LPN-B verified that the physician's order directed to give 10 units of Novolog insulin if R69's blood sugar was over 300, and that he did not follow the order. LPN-B stated, "I realize now after talking to you that I should have just given it." During a telephone interview on 1/27/14, at 3:50 p.m., RN-B stated, "If an order states to give insulin if the blood sugar is higher than a certain number, it should be given ...that's very specific...you give it as ordered." RN-B denied giving directions to not give the Novolog insulin for a blood sugar of 303. RN-B stated he would have directed the nurse to give the insulin as ordered, "because the order is very specific."	F 309		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441		

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F 441	Continued From page 41 determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure facility owned multi-use glucometers (blood glucose monitors used to check blood sugar levels) were properly sanitized between resident use to minimize the risk of transmission of potential blood borne infections, for 1 of 3 residents (R92) observed during glucose testing. This had the potential to affect 3 residents (R60, R96, R92) that have their blood glucose tested by the TMA on the Garden Cottage unit. Findings include: During an observation on 1/23/14, at 11:29 a.m., trained medication assistant (TMA)-A retrieved a glucometer and supplies from the TMA medication cart, and went into R92's room. At the completion of the blood glucose test, TMA-A	F 441	Plan of Correction F441 1. The identified glucometer was cleaned immediately after medication pass with proper disinfection wipe and allowed to dry per policy. 2. Nursing staff was re-educated on proper infection control techniques and the glucometer policy and procedure. 3. Supervisory staff will conduct random audits. 4. The data collected will be presented to the QI Committee and recommendations will be acted upon. 5. The Infection Control nurse will be responsible to monitor for continued compliance. Completed by 2/14/14	

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F 441	Continued From page 42 brought the glucometer back out to the medication cart, and used an alcohol prep to wipe the glucometer. TMA-A stated, "I always wipe it down with these," and held up the alcohol prep. When asked if that was what the facility policy directed the staff to use, TMA-A stated, "I'm not 100% sure. I think it's probably in our policy, I'm just not sure." TMA-A continued to wipe the blood glucose monitor with the alcohol prep, and stated, "Yep, it's probably in the policy to use alcohol." During an interview on 1/24/14, at 11:10 a.m. director of nursing (DON) stated, "Everyone should have their own [glucometer] in a case in their room." DON indicated that staff should always use the glucometer in the resident's room. If, for some reason, a glucometer was used from the medication cart for a resident, DON stated her expectation would be that it would have been cleaned using a saniwipe after use. DON stated, "They go through the training annually...I would be very surprised if someone didn't know how to clean them." Upon review of the facility's policy, titled Assure IV Blood Glucose Test Multi Use/Emergency Glucometer, reviewed 2/10, staff were directed to "Disinfect glucometer after each use with Super Sani-cloth germicidal wipes. Monitor should stay wet with germicidal agent for two full minutes."	F 441		
F 501 SS=E	483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility.	F 501		

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F 501	Continued From page 43 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility medical director failed to provide clinical guidance, oversight and collaboration with facility staff in the development and implementation of the facility's resident care policies related to signs and symptoms of hyperglycemia (elevated blood sugar) which had the potential to affect all 53 diabetic residents who required diabetic monitoring of blood glucose levels. Findings include: R300 was admitted to the facility on 9/10/13, after a hospitalization for acute renal failure, diabetic ketoacidosis (a life-threatening complication when the body does not produce enough insulin), and a brain aneurysm with ventriculoperitoneal shunt (used to take excess fluid from brain, and "shunt" or divert it to the abdomen for absorption) placement. While hospitalized, R300 had blood sugars greater than 1,100 milligrams per deciliter (mg/dL) which required a continuous insulin drip to return to normal levels. R300's diagnoses per the hospital discharge summary dated 9/10/13, included but were not limited to Type 1 diabetes, hypertension and stroke. R300's physician orders from the 9/13 medication administration record included: Novolog (a quick acting insulin) One unit per carbohydrate consumed with each meal Novolog sliding scale insulin with all meals per blood sugar results Lantus (a long acting insulin) 20 units with breakfast and a bedtime glucometer (blood sugar) checks four times a day	F 501	Plan of Correction F501 1. The Diabetic Policy and Change of Condition Policy were updated to include the following for diabetic residents with glucometer checks: *The physician will be contacted and asked to identify parameters for physician notification on new diabetic admissions who receive glucometer checks. *New admissions with diabetes will be asked if they can tell when their blood sugar is high or low and the information will be documented. The Medical Director gave guidance and approved the above policy	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245330	A. BUILDING _____ B. WING _____	01/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY MANOR HEALTH & REHAB CTR	520 FIRST STREET NORTHEAST SARTELL, MN 56377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 501	Continued From page 44 Review of R300's glucometer record for 9/13 included the following blood sugars: From 9/10/13 to 9/17/13 the results ranged from 71-386 with one reading of 409. On 9/18/13, at 7:00 a.m. the blood sugar was 392. At 11:00 a.m. it was 525. At 8:00 p.m. the machine could not give a number and only read as "HI". On 9/19/14 at 0010 (12:10 a.m.) the blood sugar was 515. On 9/19/13, at 7:00 a.m., the final recorded blood sugar for R300 was 524. Review of the interdisciplinary notes included the following: A note written by registered nurse (RN)-E on 9/19/13, at 12:39 a.m. identified R300 had a blood glucose level of "HI" reading on 9/18/13, at 8:00 p.m. A call was placed to the on-call physician and orders were given to administer eight units of Novolog and fax the primary physician in the morning to obtain sliding scale parameters for R300's 8:00 p.m. blood sugars. A note written by licensed practical nurse (LPN)-C on 9/19/13, at 10:44 a.m. indicated R300 had been nauseous and was dry heaving that day with a temperature of 100.2. A note written by LPN-C on 9/19/13, at 2:01 p.m. indicated staff had entered R300's room at 11:00 a.m. for therapy, when R300 was found unresponsive. Nursing staff lowered R300 to the ground, cardiopulmonary resuscitation (CPR) was initiated at 11:04 a.m. and continued until paramedics arrived.	F 501	2. Medical Director gave guidance and approved the following plan: For residents with a diagnosis of diabetes with glucometer checks the primary physicians were contacted regarding parameters identifying when to be notified of low and high blood sugars. 3. The Medical Director will continue to be involved in the implementation of resident care policies and the coordination of medical care.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	245330	A. BUILDING _____ B. WING _____	01/28/2014

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F 501	Continued From page 45 Per the time line that was provided by the facility the morning of 9/19/13, R300 awoke at her normal time, was alert and responding to staff by nodding yes or no. Blood sugar was checked at 0700 and was 524. Resident was given eight units of Novolog per insulin sliding scale and 20 units of Lantus. R300 went to breakfast and ate bites of toast and cereal. She was given two units of Novolog per carbohydrate counting orders. R300 participated in therapy from 9:30 to 9:55 a.m. and was brought back to her room. Per the nursing note written on 9/19/13 at 10:44 a.m., R300 was nauseated and dry heaving. R300 was left in her room and in her wheelchair. The desk nurse called the primary physician at 10:45 for a second attempt to follow up from the morning fax. A message was left with the primary's nurse. At 11:00 R300 was found unresponsive in her wheelchair. Staff began CPR and the desk nurse called 911 and then the primary physician was called again and was not available. A message was left again with the primary physician's nurse. Review of R300's code blue record (no date), indicated R300 passed away in the emergency room on 9/19/13, at 12:55 p.m. Review of the facility's glucometer (Assure 4) manufacturer's manual dated 4/07 revealed a reading of "HI" meant the blood sugar test result was greater than 550 mg/dL and recommended seeking immediate medical assistance. LPN-F also indicated that each resident had their own specific guidelines under the sliding scale order on when to call the physician. LPN-F was not sure of any facility policy of when to call the physician when the blood sugar was high. During interview on 1/23/14, at 12:04 p.m., RN-D	F 501	4. Medical Director will continue to annually review resident care policies at the QI meeting and as needed. 5. Quality Care deficiencies will be presented to the QI Committee for Medical Director Guidance and recommendations will be acted upon. Completed by 2/14/14	

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F 501	Continued From page 46 stated if a resident's blood sugar usually ran in the 100-200's and then was having readings in the 300-400 range, the staff would call the physician because that would be a change for the resident. RN-D also stated if the glucometer reading was too high to register on the machine a call would also be placed to the physician. RN-D further described how the physician would usually give an order for insulin administration and that the staff should recheck the blood sugar after an hour, because insulin is pretty fast acting. RN-D also suggested the staff should be rechecking the blood sugar hourly until it returned to a safe level. During interview on 1/24/14, at 10:10 a.m., the director of nursing (DON) indicated she had completed an internal quality investigation of R300's incident days following the incident. However, DON stated she wasn't sure if the information gathered had been brought to the quality assurance meetings or not. DON revealed that the staff were not educated by the facility on specific parameters on when to call the physician related to blood sugar readings and felt the staff didn't need to call R300's physician when her readings were in the 500's because, "That was her baseline." DON also indicated no reeducation or changes of policy were completed after the investigation because it was felt the staff acted appropriately. At approximately 3:10 p.m., the DON verified there was no physician involvement in the internal quality investigation. R300's medical record lacked evidence of physician notification or involvement from 8:00 p.m. on 9/18/13, until the day shift of 9/19/13, despite her blood sugars having remained elevated (based on a blood sugar reading of 515 on 9/19/13, at 12:10 a.m. post administration of	F 501		

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F 501	Continued From page 47	F 501		

fast acting insulin). The medical record lacked evidence of on-going blood sugar testing throughout the overnight hours to ensure it returned to a safe level and lacked evidence considering the impact of R300's continuous tube feeding on her elevated blood sugars. The medical record also lacked evidence to support R300's baseline blood sugars were near 500 mg/dl.

During interview on 1/24/14, at 1:03 p.m., LPN-C was not aware of any facility policy which gave guidance on when to call a physician related to blood sugar results.

During interview on 1/27/14, at 2:16 p.m., RN-E indicated R300's blood sugar had read "HI" on the evening of 9/18/13, so she called the on-call physician who gave instructions to administer the eight units of insulin for a blood sugar greater than 400 per R300's orders and to contact the primary physician in the morning to get parameters for the bedtime sliding scale. RN-E stated she then watched for symptoms of hyperglycemia, and rechecked R300's blood sugar at on 9/19/13, at 12:10 a.m., per her nursing judgment. R300's blood sugar was 515. RN-E indicated she was aware 515 was an elevated result for R300 but did not think she needed to contact the on-call physician again because R300 did not have any symptoms of hyperglycemia.

During interview on 1/28/14, at 8:21 a.m., MD-C stated it was expected that the nurses recheck a blood sugar after administration of short acting insulin and call the on call physician again if the blood sugar remained elevated. MD-C indicated

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F 501	Continued From page 48 elevated was considered when the machine read "HI" for sure, but also greater than 400. MD-C didn't think anyone would not call if the level stayed elevated as it was normal nursing judgment to call again and they wouldn't want that liability. MD-C confirmed a reading greater than 500 on a recheck warranted physician notification for sure and potential dangers for type one diabetics with blood sugars that high included decay which was the most obvious. Review of the facility's policy titled, Treatment for Diabetic Residents which was last reviewed on 7/10, gave direction to observe for and report immediately symptoms of hyperglycemia such as restlessness, tachycardia and nausea and/or vomiting. A policy specifically related to the treatment of hyperglycemia was requested however, per the DON on 1/28/14, at 2:33 p.m., no such policy existed as the medical director was more concerned about hypoglycemia and reluctant to specify parameters for treatment of hyperglycemia.	F 501		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245330	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**01/23/2014**

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COUNTRY MANOR HEALTH & REHAB CTR	**520 FIRST STREET NORTHEAST SARTELL, MN 56377**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Country Manor Health & Rehab Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. The facility was inspected as two separate buildings: Country Manor Health & Retirement is a 1 story building with no basement and is fully sprinklered. The building was constructed at 8 different times. The original building was constructed in 1970 and was determined to be of Type II(000) construction. In 1975, the 300 Wing was added to the south that was determined to be of Type II(000) construction. In 1979 the 100 Wing was added to the north that was determined to be of Type V(111) construction. In 1981 additions were added to the west and east of the 100 Wing which were determined to be Type V(111) construction. In 1984 the Chapel was added to the southeast of 300 Wing that was determined to be of Type V(111) construction. In 1996 an addition was added to the Kitchen that was determined to be of Type V(111) construction. In 2001 an addition was added to the Main Entrance/Cafe that was determined to be of Type V(111) construction. In 2011 a two story addition was added and was determined to be of Type II(111) construction. Because the original building	K 000		

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

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.

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

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K 000	Continued From page 1 and the additions do not meet the construction types allowed for existing buildings, the facility was surveyed as two buildings. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 165 beds and had a census of 150 at the time of the survey.	K 000		

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

FS330022

PRINTED: 02/25/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245330	A. BUILDING 02 - 2011 TWO STORY ADDITION B. WING _____	01/23/2014

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COUNTRY MANOR HEALTH & REHAB CTR	520 FIRST STREET NORTHEAST SARTELL, MN 56377

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOU VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Country Manor Health Care and Rehab Center's Two Story Addition was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	POC ok JB 3-5-14	

DC: 3-9-14

Exit: 1-28-14

RECEIVED
MAR - 3 2014
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brian C. Ahr | TITLE: Adm/CEO | (X6) DATE: 2-26-2014

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 By e-mail to: Barbara.lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Country Manor Health Care and Rehab Center's building 2 is a 2-story addition with no basement. The addition was constructed in 2011 and was determined to be Type II (111). The addition is fully sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 165 beds and had a census of 150 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 056		

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

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K 056	Continued From page 2 There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5. This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect all residents, visitors and staff of the facility. Findings include: On facility tour between 9:30 AM to 1:30 PM on 01/23/2014, observations reveled The following deficient conditions affecting the facility's fire sprinkler system: 1. The spare sprinkler head box was not equipped with at least 2 of every type and style of	K 056	Plan of Correction K 056 1. 3 sprinkler heads were purchased on 2/18/14 and were placed in the spare sprinkler head box in building 2. 2. The painted sprinkler heads were replaced on 2/18/2014 in the Rapid Recovery & Aquatic Center entrance. 3. Spare Sprinkler Head Check was added to the Preventative Maintenance audit to assure continued compliance. Completion date: 2/18/2014 Responsible person: Brett Avery, Maintenance Director	

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

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K 056	Continued From page 3 sprinkler heads that are being used in the facility. The observed missing spare sprinkler heads were the same type as the ones located in the Mechanical room in building 02 where the main sprinkler riser and spare sprinkler head box is located. 2. There are two painted sprinkler heads located in the receptionist area of the PT entry. This deficient practice was verified by the Maintenance Supervisor (BS).	K 056		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8187

February 13, 2014

Mr. Brian Kelm, Administrator
Country Manor Health & Rehabilitation Center
520 First Street Northeast
Sartell, Minnesota 56377

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5330024

Dear Mr. Kelm:

The above facility was surveyed on January 21, 2014 through January 28, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

and the Time Period For Correction.

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File