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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: NU85

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00467

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245356**

2.STATE VENDOR OR MEDICAID NO.
(L2) **230080000**

3. NAME AND ADDRESS OF FACILITY
(L3) **MCINTOSH SENIOR LIVING**
(L4) **600 NORTHEAST RIVERSIDE AVENUE**
(L5) **MCINTOSH, MN** (L6) **56556**

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) **09/24/2009**

6. DATE OF SURVEY **12/26/2013** (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)
12/31

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

12.Total Facility Beds **45** (L18)

13.Total Certified Beds **45** (L17)

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(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): On December 26, 2013 a Post Certification Revisit (PCR), by review of the plan of correction was completed and verfified correction of all deficiencies, effective December 3, 2014. Refer to the CMS 2567b for both health and life safety code. Effective December 3, 2014 the facility is certified for 45 skilled nursing facility beds.

17. SURVEYOR SIGNATURE — Date :
Lyla Burkman, Unit Supervisor — 02/03/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Program Specialist MPM — 03/09/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/01/1986
(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.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/24/2013
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5356

March 9, 2014

Ms. Sharlene Knutson, Administrator Administrator
McIntosh Senior Living
600 Northeast Riverside Avenue
McIntosh, Minnesota 56556

Dear Ms. Knutson:

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 December 3, 2013 the above facility is certified for:

45 Skilled Nursing Facility/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.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

February 3, 2014

Ms. Sharlene Knutson, Administrator
McIntosh Senior Living
600 Northeast Riverside Avenue
McIntosh, MN 56556

RE: Project Number 00467

Dear Ms. Knutson:

On November 13, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 25, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 26, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 9, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 25, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 3, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 25, 2013, effective December 3, 2013 and therefore remedies outlined in our letter to you dated November 13, 2013, will not be imposed.

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

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,

Lyla Burkman/bs

Lyla Burkman, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: 218-308-2104 Fax: 218-308-2122

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245356	A. Building B. Wing	12/26/2013

Name of Facility	Street Address, City, State, Zip Code
MCINTOSH SENIOR LIVING	600 NORTHEAST RIVERSIDE AVENUE MCINTOSH, MN 56556

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 F0164 Reg. # 483.10(e), 483.75(l)(4) LSC	Correction Completed 12/03/2013	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 12/03/2013	ID Prefix F0311 Reg. # 483.25(a)(2) LSC	Correction Completed 12/03/2013
ID Prefix F0371 Reg. # 483.35(i) LSC	Correction Completed 12/03/2013	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 V State Agency	Reviewed By 10562	Date: 2/3/14	Signature of Surveyor: 10562	Date: 2-3-14
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
10/25/2013				

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245356	01 - MAIN BUILDING 01	1/9/2014

Name of Facility	Street Address, City, State, Zip Code
MCINTOSH SENIOR LIVING	600 NORTHEAST RIVERSIDE AVENUE MCINTOSH, MN 56556

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0029	12/03/2013	ID Prefix Reg. # NFPA 101 LSC K0074	12/03/2013	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By ✓ State Agency	Reviewed By 10562	Date: 2/3/14	Signature of Surveyor: 10562	Date: 2/3/14
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:
10/24/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245356	A. Building B. Wing	12/26/2013

Name of Facility	Street Address, City, State, Zip Code
MCINTOSH SENIOR LIVING	600 NORTHEAST RIVERSIDE AVENUE MCINTOSH, MN 56556

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).

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ID Prefix F0371 Reg. # 483.35(i) LSC	Correction Completed 12/03/2013	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 V State Agency	Reviewed By 10562	Date: 2/3/14	Signature of Surveyor: 10562	Date: 2-3-14
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
10/25/2013				

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245356	01 - MAIN BUILDING 01	1/9/2014

Name of Facility	Street Address, City, State, Zip Code
MCINTOSH SENIOR LIVING	600 NORTHEAST RIVERSIDE AVENUE MCINTOSH, MN 56556

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0029	12/03/2013	ID Prefix Reg. # NFPA 101 LSC K0074	12/03/2013	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency ✓	Reviewed By 10562	Date: 2/3/14	Signature of Surveyor: 10562	Date: 2/3/14
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 10/24/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245356	01 - MAIN BUILDING 01	1/9/2014

Name of Facility	Street Address, City, State, Zip Code
MCINTOSH SENIOR LIVING	600 NORTHEAST RIVERSIDE AVENUE MCINTOSH, MN 56556

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).

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ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency ✓	Reviewed By 10562	Date: 2/3/14	Signature of Surveyor: 10562	Date: 2/3/14
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:
10/24/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: NU85

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00467

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245356**
2.STATE VENDOR OR MEDICAID NO.
(L2) **230080000**

3. NAME AND ADDRESS OF FACILITY
(L3) **MCINTOSH SENIOR LIVING**
(L4) **600 NORTHEAST RIVERSIDE AVENUE**
(L5) **MCINTOSH, MN** (L6) **56556**

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) **09/24/2009**

6. DATE OF SURVEY **10/24/2013** (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)
12/31

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

12.Total Facility Beds **45** (L18)

13.Total Certified Beds 45 (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(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):
At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. Please refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE Date :
Jana Bromenshenkel, HFE NEII 12/13/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 12/19/13 (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
10/01/1986
(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.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7548

November 13, 2013

Ms. Sharlene Knutson, Administrator Administrator
McIntosh Senior Living
600 Northeast Riverside Avenue
McIntosh, Minnesota 56556

RE: Project Number S5356028

Dear Ms. Knutson:

On October 24, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

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

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

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

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

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.

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:

Lyla Burkman, Unit Supervisor
Minnesota Department of Health
705 - 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933

Telephone: (218) 308-2104
Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 4, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 4, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that

substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by January 24, 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 April 24, 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,

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

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245356	A. BUILDING _____ B. WING _____ RECEIVED DEC 02 2013	10/25/2013 per JB

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCINTOSH SENIOR LIVING	600 NORTHEAST RIVERSIDE AVENUE MCINTOSH, MN 56556

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	Approved c addendum 12/13/13 SB	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of	F 164	**F164** **On 11/21/13 R38's insulin had been changed by the medical director to decrease the number of daily injections. Long acting Lantus was increased and Novalog was placed on hold. Lantus insulin is scheduled at bedtime and his injections will now be giving in his room. Care plan was also updated on the above date. All current residents that receive injections will be reviewed and their plan of care will be updated as needed. The Policy for giving injections was updated to ensure privacy is maintained for all current and future residents. By 12/3/13, all nursing staff will be educated on our policy**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	11/25/13

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 164	Continued From page 1 the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure privacy was provided during insulin administration for 1 of 2 residents (R38) in the sample who were observed during insulin administration. Findings include: R38's diagnoses included dementia, Alzheimer's disease, obesity, psychosis and diabetes. R38's plan of care (POC) dated 6/5/13, indicated R38 had a memory deficit, was hard of hearing and rarely understood others. The POC also indicated R38 took medication with encouragement and directed staff to reapproach if R38 refused or became resistive. The POC also directed staff to explain all procedures step by step, giving direction and to repeat or demonstrate as needed for res understanding. In addition, the POC indicated staff could administer insulin when in the dining room to prevent further disruption and R38's need to be returned to own room. The POC indicated R38 would holler out during insulin injection and directed staff to attempt to distract R38 by encouraging card playing, piano, drawing, puzzles or visiting. On 10/21/13, at 5:15 p.m. R38 was observed in the day room near the main dining room, seated in a recliner. R38 was heard yelling out "no, don't	F 164	**F-164 cont.** **for giving injections and maintaining privacy. The RN/LPN designee will audit 2 injections each week for 2 months to ensure policy is being followed. The Quality Assurance committee reviewed on 11/21/13 and corrective actions will be completed by 12/3/13.**	

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F 164	Continued From page 2 do that." At this time, licensed practical nurse (LPN)-A was observed lifting R38's shirt up while holding an insulin syringe in the other hand. Another staff member was observed holding down R38's hands onto the arms of the chair. R38 continued to yell out "no, don't do that." LPN-A was observed to administer the insulin into R38's abdomen. During the administration of the insulin R38 yelled out "ouch," "don't do that," "ouch." LPN- A stated, "We have to do that to be able to give the insulin." There were eight other residents in the day room that observed the insulin administration. On 10/23/13, at 11:34 a.m. R38 was observed seated at a table in the activity room with two other male residents. Two female residents were also observed in the activity room. At this time, LPN-A was observed to draw up 13 units of Novolog (insulin) into a syringe, carried the syringe into the activity room and gave R38 a cookie. When R38 picked up the cookie, LPN-A was observed to lift up R38's shirt and attempted to administered the insulin into R38's abdomen. R38 was observed to become instantly agitated, dropped the cookie and attempted to resist the insulin injection by grabbing the nurses hand, grabbing towards his shirt in an attempt to pull it back down over his abdomen. When R38 became resistive activity assistant (AA)-A took the resident's hands and held them down while the LPN-A quickly administered the resident the insulin into the abdomen. All four residents in the activity room observed the aforementioned insulin administration. After the insulin was administered to R38, the resident quickly calmed down and ate the cookie given to him. On 10/23/13, at 11:45 a.m. LPN-A confirmed she	F 164		

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F 164	Continued From page 3 had tried to use the cookie as a diversion to distract R38 before she attempted to inject the insulin. LPN-A further stated sometimes distracting R38 on something other than the insulin injection made the administration of the insulin go more smoothly. LPN-A confirmed she had someone hold R38's arm so that she could get to the area she needed in order to inject the medication. LPN-A also confirmed all four of the other residents present in the activity room could clearly observe R38 resisting, being held down and given an injection in the abdomen. She stated all four of the other residents were not interviewable and could not comment if this practice bothered them. LPN-A stated R38 had a POC developed related to the insulin administration. On 10/25/13, at approximately 10:00 a.m. the director of nurses (DON) stated R38's family had given the facility consent to administer R38 insulin in a public area after the facility reviewed the risk versus the benefit of R38 not receiving the insulin injection. The DON stated the interdisciplinary team had considered how this practice may affect other residents or visitors who witnessed this procedure but felt it was more important R38 received the insulin injection. She confirmed the interdisciplinary team had not developed strategies to provide R38 insulin while maintaining his privacy and the privacy of others who may not wish to witness R38's administration of insulin.	F 164		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility	F 282		

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F 282	Continued From page 4 must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, and document review the facility failed to provide ambulation services according to the written plan of care (POC) for 2 of 3 residents (R14, R39) reviewed for ambulation. Findings include: R14 was not provided ambulation services as directed by the POC. R14 was diagnosed with dementia, a history of falls and blindness. R14 resided on the special care unit (SCU). R14's current POC initiated 9/20/13, indicated R14 had a nursing restorative program. The restorative care program dated 3/6/13, directed staff to ambulate R14 100-150 feet with the walker and a gait belt two-three times a day. The restorative ambulation records were as follows: -May 2013-ambulated 53 out of 62 opportunities. -June 2013-ambulated 55 out of 60 opportunities. -July- 2013-ambulated 45 out of 62 opportunities. -August 2013-ambulated 51 out of 62 opportunities. -September 2013-ambulated per the care plan. -October 2013-ambulated 26 out of 44 opportunities.	F 282	**F282** **On 11/25/13 R14 & R39's plan of care has been revised to reflect current restorative nursing program. All new and current residents with restorative nursing programs will all be reviewed and care plans updated to reflect changes by the DON/ADON by 12/3/13. Restorative nursing care plan policy has been revised and updated. All nursing staff will be educated on the new policy and the importance of following POC by 12/3/13. To ensure full compliance the DON will audit 2 care plans a week to ensure programs are reflected correctly in the POC. The Quality Assurance committee reviewed on 11/21/13 and corrective actions will be completed by 12/3/13.**	

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F 282	Continued From page 5	F 282		

On 10/24/13, at 1:29 p.m. the director of nursing (DON) reviewed the ambulation records with the surveyor for the months of May through October 2013, and verified the findings. The DON stated she was aware there was problems with the restorative ambulation program and she would be making changes. In addition, the DON verified the care plan was not followed and stated the policy would be revised.

The Rehab Nursing Program policy dated 6/15/10, indicated nursing procedures were incorporated into charting guidelines to assure proper documentation. In addition, the policy indicated the registered nurse would review the program monthly and quarterly.
R39 was not provided rehabilitation/restorative services as directed by the POC.

R39's diagnoses included a left TKA (total knee arthroplasty) on 5/21/13, and hemiplegia following cerebrovascular accident (stroke).

R39's POC revised on 6/17/13, indicated R39 was dependent on staff for all activities of daily living. The POC also indicated R39 had a left sided range of motion (ROM) deficit. The POC directed staff to walk R39 25-100 ft daily [with assistance of 2-3 staff], with a gait belt and forward wheeled walker, to follow behind R39 with a wheelchair and to allow rest periods as needed. In addition, the POC indicated R39 was to do 7-10 sit to stand exercises daily. For the sit to stand exercises, the POC directed staff to cue R39 to lean forward, head over toes and to push up from the wheelchair. The POC also directed staff to strongly encourage R39 to do more each

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F 282	Continued From page 6 day. Review of the REHABILITATION/RESTORATIVE SERVICE DELIVERY RECORD from 10/1/13, through 10/24/13, indicated R39 completed the sit to stand exercises on two out of 23 opportunities and ambulated eight out of 66 opportunities. On 10/24/13, at 10:03 a.m. the DON reviewed the residents REHABILITATION/RESTORATIVE SERVICE DELIVERY RECORD for October 2013, and confirmed that R39 had not received restorative rehabilitation services as directed by the POC.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide ambulation services according to the assessed need for 2 of 3 residents (R14, R39) reviewed for ambulation. Findings include: R14 was diagnosed with dementia, a history of falls and blindness. R14 resided on the special care unit (SCU). The quarterly Minimum Data Set (MDS) dated 9/21/13, indicated R14 had a memory deficit with	F 311	**F311** **On 11/25/13 R14 & R39's restorative nursing programs were reviewed and revised by the DON/ADON to meet the resident's needs to maintain the residents' current abilities. All new and current residents on restorative nursing programs will be reviewed and updated by DON/ADON by 12/3/13.** **Our restorative nursing program policy has been updated and all nursing and activity staff will be educated by 12/3/13 on our policy and the importance of following the programs and signing off that program was completed for each resident. To ensure full compliance the DON will**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 311	Continued From page 7 moderately impaired decision making skills. The MDS also indicated R14 required one staff limited assistance for ambulation. The Activity of Daily Living (ADL) Care Area Assessment (CAA) dated 4/9/13, indicated R14 had memory impairment, ambulated with the use of a walker and was supervised when walking off of the unit. R14's current plan of care (POC) initiated 9/20/13, indicated R14 had a nursing restorative program for ambulation. The restorative care program form dated 3/6/13, directed staff to ambulate R14 100-150 feet with the walker and a gait belt two-three times a day. The restorative ambulation documentation records revealed the following: -May 2013-ambulated 53 out of 62 opportunities. -June 2013-ambulated 55 out of 60 opportunities. -July- 2013-ambulated 45 out of 62 opportunities. -August 2013-ambulated 51 out of 62 opportunities. -September 2013-ambulated as the POC directed. -October 2013-ambulated 26 out of 44 opportunities. On 10/23/13, at 12:42 p.m. nursing assistant (NA)-A stated R14 was to be ambulated with his walker by the NAs. She added, the activity staff and the nurses would also assist R14 with ambulation. At 12:47 p.m. NA-A reviewed the restorative ambulation record with the surveyor and stated R14 was to ambulate 100-150 feet two-three times a day and verified the ambulation was not consistently documented. NA-A stated she had	F 311	**F311 cont** **audit 4 restorative nursing programs each week for 2 months to ensure programs are being completed and signed off. The Quality Assurance committee reviewed on 11/21/13 and corrective actions will be completed by 12/3/13.**	

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F 311	Continued From page 8 not had time to ambulate R14 yet today. At 1:45 p.m. NA-A was observed to assist R14 to ambulate off the unit with a gait belt and the walker. R14 ambulated a total of 400 feet. On 10/24/13, at 9:32 a.m. the director of nursing (DON) stated the physical therapy evaluation dated 6/14/13, recommended R14 continue with the restorative nursing program dated 3/6/13. The DON verified R14 was to ambulate two-three times a day with the walker 100-150 feet. The DON also stated she reviewed the ambulation records at the end of each month. She added, she had left notes for the involved staff, and felt the ambulation was being done and not documented. On 10/24/13, at 1:29 p.m. the DON reviewed the ambulation records with the surveyor for the months of May through October 2013, and verified the findings. The DON stated she was aware there was problems with the restorative ambulation program and she would be making changes. In addition, the DON verified R14's POC was not followed and stated the policy would be revised. The Rehab Nursing Program policy dated 6/15/10, indicated nursing procedures were incorporated into charting guidelines to assure proper documentation. In addition, the policy indicated the registered nurse would review the program monthly and quarterly. R39 was not provided rehabilitation/restorative services according to the residents assessed need. R39 diagnoses included left TKA (total knee arthroplasty) on 5/21/13, and hemiplegia following	F 311		

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F 311	Continued From page 9 cerebrovascular accident (stroke). The annual MDS dated 8/21/13, indicated R39 required two staff assist for transfers and ambulation R39's POC revised 6/17/13, indicated R39 was dependent on staff for all activities of daily living due to a stroke with left sided deficit. The POC directed two-three staff to ambulate R39 25-100 feet with a forward wheeled walker, gait belt and rest periods two-three times a day. The POC also directed staff to provide seven to 10 sit to stand exercises by cueing R39 to lean forward, head over toes and push up from the wheelchair, daily. Additionally, the POC directed staff to strongly encourage R39 to do more each day. Review of the physical therapy progress notes revealed R39 had received formal physical therapy (PT) services twice daily following the left TKA on 5/21/13. The notes also indicated R39 was discharged from PT 8/2/13, and was started on a restorative rehabilitative program. The notes indicated R39 was again started on PT on 9/22/13, for increased strength and balance needs. On 10/23/13, R39 was discharged from PT as R39 had reached the maximum potential. The physical therapist had indicated in the physical therapy discharge summary that R39 was to continue with the previous restorative rehabilitative plan. Review of the resident's rehabilitation/restorative service delivery record for October 2013, revealed R39 had been provided formal physical and occupational therapy services from 9/20/13 until 10/18/13.	F 311		

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	245356	A. BUILDING _____ B. WING _____	10/25/13

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MCINTOSH SENIOR LIVING	600 NORTHEAST RIVERSIDE AVENUE MCINTOSH, MN 56556

(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 311	Continued From page 10 Review of the physical therapy Therapy Nursing Communication Note dated 10/2/13, indicated the physical therapist had ordered staff to ambulate R39 two times a day with two staff, a front wheeled walker and a gait belt 20-50 feet every day in addition to the formal physical therapy being provided. The physical therapist also ordered R39's restorative program to include sit to stand exercises, at least 10 repetitions, one time a day. Review of the REHABILITATION/RESTORATIVE SERVICE DELIVERY RECORD revealed from October 1, 2013, through October 24, 2013, R39 completed the sit to stand program on 2 occasions out of 23 opportunities, and completed the ambulation program on 8 occasions out of 66 opportunities. On 10/23/13, from 7:00 a.m. to 2:30 p.m. R39 was observed to not have been been offered restorative rehabilitation ambulation or sit to stand exercises. On 10/24/13, at 9:12 a.m. NA-B verified she was responsible for providing care to R39. When asked what restorative rehabilitative services she was to provide R39, NA-B stated, "I don't know." NA-B confirmed she was responsible for the resident's care but then stated the certified occupational therapy assistant (COTA) was responsible for the resident's ambulation services. NA-B stated she was not aware R39 was also supposed to participate in sit to stand exercises, at least 10 repetitions, daily. On 10/24/13, at 9:14 a.m. the assistant director of nursing (ADON) stated the NA's were	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 311	Continued From page 11 responsible for providing restorative or rehabilitative services including walking and transfer activities. The ADON further stated the COTA was also responsible for providing the ambulation services ordered for R39. On 10/24/13, at 10:10 a.m. the COTA stated she was only responsible for completing R39's walking program and not the sit to stand exercises program. The COTA stated that she was not aware physical therapy had recommended R39 be ambulated twice daily during the time the resident was getting formal physical therapy services twice a day, and confirmed she had not offered R39 ambulation services during the period of time R39 received formal physical therapy services (9/22/13-10/18/13). On 10/24/13, at 10:03 a.m. the DON stated "everyone" was supposed to help with restorative rehabilitative services. She also stated the nursing assistants, nurses and activity director, who was a COTA assisted with restorative rehabilitative services. Additionally, the DON stated the COTA provided rehabilitative services for some of the more challenging residents including R39. The DON reviewed R39's REHABILITATION/RESTORATIVE SERVICE DELIVERY RECORD for October 2013, and confirmed R39 had not received restorative rehabilitation services as recommended by physical therapy. On 10/24/13, at 11:23 a.m. R39 was observed ambulating 100 feet with a front wheeled walker, gait belt and two staff assistance. The sit to stand exercises was not offered during this observation.	F 311		

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F 371	Continued From page 12	F 371	**F371**	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the microwaves in the primary nourishment room on the east common corridor and on the special care unit (SCU) were clean which had the potential to affect 33 of 33 residents on the east corridor who utilized the microwave and 12 of 12 residents on the SCU which staff utilized for resident food. In addition, the facility failed to ensure toast was not prepared with bare hands for 1 of 12 residents (R3) who resided in the SCU. Findings include: On 10/21/13, at 5:20 p.m. the social service designee (SSD) was observed, with bare hands, preparing two 2 slices of toast for R3 on the SCU. The SSD was observed to touch the toast with her bare hands. On 10/22/13, at 8:43 a.m. the activity program coordinator (APD) was observed preparing toast	F 371	**On 10/25/13 an education note was put out for nursing, activities and dietary staff on glove usage when handling resident food, wiping out microwaves if there is a spill and the Dietary Manager cleaning microwaves thoroughly one time a week. On 10/25/13 our policy was updated on cleaning microwaves and the Director of Food service will be ensuring the microwaves are thoroughly cleaned one time per week. Also the importance of wearing gloves when touching resident's food. All staff will be educated by 12/3/13 again on our policies regarding microwave cleaning and glove usage when handling resident foods. The Administrator/DON will audit 2 times a week for 2 months to ensure proper glove usage with food is being followed. The Administrator will audit 2 times a week for 2 months to ensure the cleanliness of the microwave is being followed. The Quality Assurance**	

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F 371	Continued From page 13 for R3 on the SCU. With bare hands, the APD was observed to remove two slices of toast out of the toaster and hold the toast in place while she buttered them with a knife. On 10/24/13, at 9:46 a.m. the director of nursing (DON) stated staff had infection control training and were informed they could not touch toast with their bare hands. On 10/24/13, at 9:55 a.m. the SSD stated she knew she was not to touch the toast with her bare hands. In addition, the SSD stated she had training on this issue. On 10/24/13, at 10:07 a.m. the director of food services (DFS) stated the staff need to be reminded about the glove policy. On 10/24/13, at 10:19 a.m. the microwave in the nourishment room was observed to have dried food debris in it. The DFS verified the microwave was not clean. On 10/24/13, at 10:21 a.m. the microwave on the SCU unit had crumbs in it and the DFS verified the microwave was not clean. The DFS stated she did not know who was responsible for cleaning the microwave. On 10/24/13, at 10:27 a.m. the assistant director of nursing (ADON) stated she did not know who was responsible for cleaning the microwaves. On 10/24/13, at 10:34 a.m. the (APD) stated she knew she was supposed to wear gloves when touching food. On 10/24/13, at 11:02 a.m. the ADON stated the	F 371	**F371 cont** **committee reviewed on 11/21/13 and corrective actions will be completed by 12/3/13.**	

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F 371	Continued From page 14 facility did not have a policy which addressed who would clean the microwaves. The undated glove usage policy indicated gloves would be worn when touching food.	F 371		

McIntosh Senior Living

600 Riverside Ave NE
McIntosh, MN 56556

Phone: 218-563-2715
Fax: 218-563-2395

12/11/13

Lyla Burkman
MN Department of Health
Bemidji, MN 56601

Dear Lyla,

I am writing to you in regards of our Plan of Correction that was submitted to you from our survey that was completed on 10/25/13. I have an addendum for the following F tags:

- F164-The RN/LPN will monitor 2 insulin injection administrations a week for 2 months to ensure policy is being followed.
- F282-The DON will audit 2 care plans a week and ensure that the care plans are being followed accordingly.
- F311-The DON will observe 4 restorative nursing programs each week for two months to ensure that the plans are being followed.
- F371-The Administrator/DON will monitor 2 times a week for 2 months to ensure that staff are using proper glove usage when handling resident food.
- F371-The Administrator will monitor 2 times a week for 2 months to ensure the microwaves are cleaned properly.

If you have any further questions or concerns please let me know.

Sincerely,

Sharlene Knutson, Administrator
Licensed Social Worker

Received & Approved 12/13/13 SB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245356	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/24/2013

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey McIntosh Senior Living 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail to:	K 000	POC ok PS 12-13-13 RECEIVED DEC 3 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 12-4-13

EXIT: 10-24-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	11/25/13

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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	245356	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/24/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Barbara.Lundberg@state.mn.us Fax Number 651-215-0525 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 McIntosh Senior Living is a 1-story building without a basement. The building was built in 1983 and was determined to be Type V (111) construction. The facility is separated into 4 smoke compartments by 1-hour fire barriers. The facility is completely sprinkler protected with standard response sprinkler heads, which are installed in accordance with NFPA 13 Standard for Installation of Automatic Sprinkler Systems 1999 edition. The facility has a fire alarm system that includes corridor smoke detection and smoke detection in all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. All hazardous areas have automatic fire detection in accordance with the Minnesota State Fire Code 2007 edition. The fire alarm system has automatic fire department notification. The facility has a capacity of 45 beds and had a	K 000		

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K 000	Continued From page 2 census of 40 at the time of the survey. The facility was surveyed as one building. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations and testing of corriodr doors, it was determined that one of ten hazardous area corridor doors tested is not in accordance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 18.3.2.1. This deficient practice could allow the products of combustion to travel from this hazardous area into the corridor system if a fire occurs within the room, which could negatively impact all 50 of the residents, the staff and any visitors of the facility. Findings include: Observations during the facility tour on October 24, 2013, between 9:15 am and 11:30 am, by	K 029	**K029** **On 10/24/13 the laundry room door was fixed to ensure that the door closed and latched in accordance with NFPA 101. The Maintenance supervisor will audit 2 times a week for 2 months to ensure combustion cannot travel. The Quality Assurance committee reviewed on 11/21/13 and corrective actions will be completed by 12/3/13.**	

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K 029	Continued From page 3 surveyor 03006, revealed that laundry corridor door to close and latch when allowed to become self-closing. The Director of Maintenance verified this finding during the facility tour and with the Administrator at the exit conference.	K 029		
K 074 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 This STANDARD is not met as evidenced by: Observations and an interview with staff revealed that some window treatments could not be documented as being flame resistant in accordance with NFPA 701 Standard Methods of Fire Tests for Flame Propagation of Textiles and	K 074	**K074** **On 11/19/13 MSL received verification that the horizontal blinds in the west day room and the finance office (actually the Medical records office) meets the minimum requirement of the NFPA 701 scale testing. The maintenance supervisor placed the documentations in the Fire rating binder.** **The Quality Assurance committee reviewed on 11/21/13 and corrective actions will be completed by 12/3/13.**	

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	245356	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/24/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 074	Continued From page 4 Films, 1999 edition, as required by NFPA 101 The Life Safety Code (LSC) 2000 edition Section 10.3.1. Combustible window treatments that do not meet the flame resistive requirements could add to a fire which will negatively impact all residents, staff and visitors within the rooms the curtains are in. Findings include: Observations during the facility tour on October 24, 2013, between 9:15 am and 11:30 am, by surveyor 03006, revealed that the horizontal window blinds in the west day room and the finance office could not be documented as meeting NFPA 701. The Director of Maintenance verified this finding during the facility tour and with the Administrator at the exit conference.	K 074		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7548

November 13, 2013

Ms. Sharlene Knutson, Administrator Administrator
McIntosh Senior Living
600 Northeast Riverside Avenue
McIntosh, Minnesota 56556

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5356028

Dear Ms. Knutson:

The above facility was surveyed on October 21, 2013 through October 24, 2013 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:

Lyla Burkman, Unit Supervisor
Minnesota Department of Health
705 - 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933

Telephone: (218) 308-2104
Fax: (218) 308-2122

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,

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

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00467	A. BUILDING: _____ B. WING _____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCINTOSH SENIOR LIVING	600 NORTHEAST RIVERSIDE AVENUE MCINTOSH, MN 56556

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On October 21, 22, 23, 24, and 25, 2013, surveyors of this Department's staff, visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MCINTOSH SENIOR LIVING	600 NORTHEAST RIVERSIDE AVENUE MCINTOSH, MN 56556

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On October 21, 22, 23, 24, and 25, 2013, surveyors of this Department's staff, visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance	2 000		

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	00467	A. BUILDING: _____ B. WING _____	10/25/2013

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2 000	Continued From page 1 Monitoring, Licensing and Certification Program; 705 5th St. N.W., Suite A, Bemidji, MN 56601-2933.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: F282 Based on interview, and document review the facility failed to provide ambulation services according to the written plan of care (POC) for 2 of 3 residents (R14, R39) reviewed for ambulation. Findings include: R14 was not provided ambulation services as directed by the POC. R14 was diagnosed with dementia, a history of falls and blindness. R14 resided on the special care unit (SCU). R14's current POC initiated 9/20/13, indicated R14 had a nursing restorative program. The restorative care program dated 3/6/13, directed staff to ambulate R14 100-150 feet with the walker and a gait belt two-three times a day.	2 565		

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2 565	Continued From page 2 The restorative ambulation records were as follows: -May 2013-ambulated 53 out of 62 opportunities. -June 2013-ambulated 55 out of 60 opportunities. -July- 2013-ambulated 45 out of 62 opportunities. -August 2013-ambulated 51 out of 62 opportunities. -September 2013-ambulated per the care plan. -October 2013-ambulated 26 out of 44 opportunities. On 10/24/13, at 1:29 p.m. the director of nursing (DON) reviewed the ambulation records with the surveyor for the months of May through October 2013, and verified the findings. The DON stated she was aware there was problems with the restorative ambulation program and she would be making changes. In addition, the DON verified the care plan was not followed and stated the policy would be revised. The Rehab Nursing Program policy dated 6/15/10, indicated nursing procedures were incorporated into charting guidelines to assure proper documentation. In addition, the policy indicated the registered nurse would review the program monthly and quarterly. R39 was not provided rehabilitation/restorative services as directed by the POC. R39's diagnoses included a left TKA (total knee arthroplasty) on 5/21/13, and hemiplegia following cerebrovascular accident (stroke). R39's POC revised on 6/17/13, indicated R39 was dependent on staff for all activities of daily living. The POC also indicated R39 had a left	2 565		

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2 565	Continued From page 3 sided range of motion (ROM) deficit. The POC directed staff to walk R39 25-100 ft daily [with assistance of 2-3 staff], with a gait belt and forward wheeled walker, to follow behind R39 with a wheelchair and to allow rest periods as needed. In addition, the POC indicated R39 was to do 7-10 sit to stand exercises daily. For the sit to stand exercises, the POC directed staff to cue R39 to lean forward, head over toes and to push up from the wheelchair. The POC also directed staff to strongly encourage R39 to do more each day. Review of the REHABILITATION/RESTORATIVE SERVICE DELIVERY RECORD from 10/1/13, through 10/24/13, indicated R39 completed the sit to stand exercises on two out of 23 opportunities and ambulated eight out of 66 opportunities. On 10/24/13, at 10:03 a.m. the DON reviewed the residents REHABILITATION/RESTORATIVE SERVICE DELIVERY RECORD for October 2013, and confirmed that R39 had not received restorative rehabilitation services as directed by the POC. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing	2 915		

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2 915	Continued From page 4 home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: F311 Based on observation, interview and document review, the facility failed to provide ambulation services according to the assessed need for 2 of 3 residents (R14, R39) reviewed for ambulation. Findings include: R14 was diagnosed with dementia, a history of falls and blindness. R14 resided on the special care unit (SCU). The quarterly Minimum Data Set (MDS) dated 9/21/13, indicated R14 had a memory deficit with moderately impaired decision making skills. The MDS also indicated R14 required one staff limited assistance for ambulation. The Activity of Daily	2 915		

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2 915	Continued From page 5 Living (ADL) Care Area Assessment (CAA) dated 4/9/13, indicated R14 had memory impairment, ambulated with the use of a walker and was supervised when walking off of the unit. R14's current plan of care (POC) initiated 9/20/13, indicated R14 had a nursing restorative program for ambulation. The restorative care program form dated 3/6/13, directed staff to ambulate R14 100-150 feet with the walker and a gait belt two-three times a day. The restorative ambulation documentation records revealed the following: -May 2013-ambulated 53 out of 62 opportunities. -June 2013-ambulated 55 out of 60 opportunities. -July- 2013-ambulated 45 out of 62 opportunities. -August 2013-ambulated 51 out of 62 opportunities. -September 2013-ambulated as the POC directed. -October 2013-ambulated 26 out of 44 opportunities. On 10/23/13, at 12:42 p.m. nursing assistant (NA)-A stated R14 was to be ambulated with his walker by the NAs. She added, the activity staff and the nurses would also assist R14 with ambulation. At 12:47 p.m. NA-A reviewed the restorative ambulation record with the surveyor and stated R14 was to ambulate 100-150 feet two-three times a day and verified the ambulation was not consistently documented. NA-A stated she had not had time to ambulate R14 yet today. At 1:45 p.m. NA-A was observed to assist R14 to ambulate off the unit with a gait belt and the walker. R14 ambulated a total of 400 feet.	2 915		

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2 915	Continued From page 6 On 10/24/13, at 9:32 a.m. the director of nursing (DON) stated the physical therapy evaluation dated 6/14/13, recommended R14 continue with the restorative nursing program dated 3/6/13. The DON verified R14 was to ambulate two-three times a day with the walker 100-150 feet. The DON also stated she reviewed the ambulation records at the end of each month. She added, she had left notes for the involved staff, and felt the ambulation was being done and not documented. On 10/24/13, at 1:29 p.m. the DON reviewed the ambulation records with the surveyor for the months of May through October 2013, and verified the findings. The DON stated she was aware there was problems with the restorative ambulation program and she would be making changes. In addition, the DON verified R14's POC was not followed and stated the policy would be revised. The Rehab Nursing Program policy dated 6/15/10, indicated nursing procedures were incorporated into charting guidelines to assure proper documentation. In addition, the policy indicated the registered nurse would review the program monthly and quarterly. SUGGESTED METHOD FOR CORRECTION: The DON or designee(s) could review and revise as necessary the policies and procedures regarding the need for assistance with restorative rehabilitative services. The DON or designee (s) could provide training for all appropriate staff on these policies and procedures and importance of documentation. The DON or designee (s) could monitor to assure all residents are receiving	2 915		

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2 915	Continued From page 7 adequate and appropriate care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
21000	MN Rule 4658.0610 Subp. 4 Dietary Staff Requirements-Hygiene. Subp. 4. Hygiene. Dietary staff must thoroughly wash their hands and the exposed portions of their arms with soap and warm water in a hand washing facility before starting work, during work as often as is necessary to keep them clean, and after smoking, eating, drinking, using the toilet, or handling soiled equipment or utensils. Dietary staff must keep their fingernails clean and trimmed. This MN Requirement is not met as evidenced by: F371 Based on observation, interview and document review, the facility failed to ensure toast was not prepared with bare hands for 1 of 12 residents (R3) who resided in the SCU. Findings include: On 10/21/13, at 5:20 p.m. the social service designee (SSD) was observed, with bare hands, preparing two 2 slices of toast for R3 on the SCU. The SSD was observed to touch the toast with her bare hands. On 10/22/13, at 8:43 a.m. the activity program coordinator (APD) was observed preparing toast	21000		

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21000	Continued From page 8 for R3 on the SCU. With bare hands, the APD was observed to remove two slices of toast out of the toaster and hold the toast in place while she buttered them with a knife. On 10/24/13, at 9:46 a.m. the director of nursing (DON) stated staff had infection control training and were informed they could not touch toast with their bare hands. On 10/24/13, at 9:55 a.m. the SSD stated she knew she was not to touch the toast with her bare hands. In addition, the SSD stated she had training on this issue. On 10/24/13, at 10:07 a.m. the director of food services (DFS) stated the staff need to be reminded about the glove policy. On 10/24/13, at 10:34 a.m. the (APD) stated she knew she was supposed to wear gloves when touching food. The undated glove usage policy indicated gloves would be worn when touching food. SUGGESTED METHOD OF CORRECTION: The Director of Dietary Services could develop a policy and procedure to ensure that food was served in a sanitary manner. Staff could receive training regarding hand washing and glove use to ensure knowledge of safe food handling while serving residents food. Monitoring could occur to ensure food was served in a safe and sanitary manner. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21000		

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21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: F371 Based on observation, interview and document review, the facility failed to ensure the microwaves in the primary nourishment room on the east common corridor and on the special care unit (SCU) were clean which had the potential to affect 33 of 33 residents on the east corridor who utilized the microwave and 12 of 12 residents on the SCU which staff utilized for resident food. Findings include: On 10/24/13, at 10:19 a.m. the microwave in the nourishment room was observed to have dried food debris in it. The DFS verified the microwave was not clean. On 10/24/13, at 10:21 a.m. the microwave on the SCU unit had crumbs in it and the DFS verified the microwave was not clean. The DFS stated she did not know who was responsible for cleaning the microwave. On 10/24/13, at 10:27 a.m. the assistant director of nursing (ADON) stated she did not know who was responsible for cleaning the microwaves. On 10/24/13, at 11:02 a.m. the ADON stated the	21015		

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21015	Continued From page 10 facility did not have a policy which addressed who would clean the microwaves. A SUGGESTED METHOD FOR CORRECTION: The administrator and the dietary manager could review and revise food service policies and procedures to assure the microwaves are maintained in a sanitary manner. Staff could be trained as necessary and a cleaning schedule developed. The dietary manager could monitor the cleanliness of the microwaves on a regularly basis. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21855	MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance. This MN Requirement is not met as evidenced by: F 164 Based on observation, interview and document review, the facility failed to ensure privacy was provided during insulin administration for 1 of 2	21855		

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21855	Continued From page 11 residents (R38) in the sample who were observed during insulin administration. Findings include: R38's diagnoses included dementia, Alzheimer's disease, obesity, psychosis and diabetes. R38's plan of care (POC) dated 6/5/13, indicated R38 had a memory deficit, was hard of hearing and rarely understood others. The POC also indicated R38 took medication with encouragement and directed staff to reapproach if R38 refused or became resistive. The POC also directed staff to explain all procedures step by step, giving direction and to repeat or demonstrate as needed for res understanding. In addition, the POC indicated staff could administer insulin when in the dining room to prevent further disruption and R38's need to be returned to own room. The POC indicated R38 would holler out during insulin injection and directed staff to attempt to distract R38 by encouraging card playing, piano, drawing, puzzles or visiting. On 10/21/13, at 5:15 p.m. R38 was observed in the day room near the main dining room, seated in a recliner. R38 was heard yelling out "no, don't do that." At this time, licensed practical nurse (LPN)-A was observed lifting R38's shirt up while holding an insulin syringe in the other hand. Another staff member was observed holding down R38's hands onto the arms of the chair. R38 continued to yell out "no, don't do that." LPN-A was observed to administer the insulin into R38's abdomen. During the administration of the insulin R38 yelled out "ouch," "don't do that," "ouch." LPN- A stated, "We have to do that to be able to give the insulin." There were eight other residents in the day room that observed the	21855		

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21855	Continued From page 12 insulin administration. On 10/23/13, at 11:34 a.m. R38 was observed seated at a table in the activity room with two other male residents. Two female residents were also observed in the activity room. At this time, LPN-A was observed to draw up 13 units of Novolog (insulin) into a syringe, carried the syringe into the activity room and gave R38 a cookie. When R38 picked up the cookie, LPN-A was observed to lift up R38's shirt and attempted to administered the insulin into R38's abdomen. R38 was observed to become instantly agitated, dropped the cookie and attempted to resist the insulin injection by grabbing the nurses hand, grabbing towards his shirt in an attempt to pull it back down over his abdomen. When R38 became resistive activity assistant (AA)-A took the resident's hands and held them down while the LPN-A quickly administered the resident the insulin into the abdomen. All four residents in the activity room observed the aforementioned insulin administration. After the insulin was administered to R38, the resident quickly calmed down and ate the cookie given to him. On 10/23/13, at 11:45 a.m. LPN-A confirmed she had tried to use the cookie as a diversion to distract R38 before she attempted to inject the insulin. LPN-A further stated sometimes distracting R38 on something other than the insulin injection made the administration of the insulin go more smoothly. LPN-A confirmed she had someone hold R38's arm so that she could get to the area she needed in order to inject the medication. LPN-A also confirmed all four of the other residents present in the activity room could clearly observe R38 resisting, being held down and given an injection in the abdomen. She stated all four of the other residents were not	21855		

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21855	Continued From page 13 interviewable and could not comment if this practice bothered them. LPN-A stated R38 had a POC developed related to the insulin administration. On 10/25/13, at approximately 10:00 a.m. the director of nurses (DON) stated R38's family had given the facility consent to administer R38 insulin in a public area after the facility reviewed the risk versus the benefit of R38 not receiving the insulin injection. The DON stated the interdisciplinary team had considered how this practice may affect other residents or visitors who witnessed this procedure but felt it was more important R38 received the insulin injection. She confirmed the interdisciplinary team had not developed strategies to provide R38 insulin while maintaining his privacy and the privacy of others who may not wish to witness R38's administration of insulin. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee(s) could review and revise as necessary the policies and procedures regarding resident personal privacy. The DON, or designee(s) could provide an in-service for all appropriate staff on providing personal privacy while caring for each resident. The DON, or designee(s) could monitor to assure each resident 's personal privacy. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21855		