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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: OPB6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00351

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245263**

2.STATE VENDOR OR MEDICAID NO.
(L2) **909545400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GLENCOE REGIONAL HEALTH SERVICES**
(L4) **1805 HENNEPIN AVENUE NORTH**
(L5) **GLENCOE, MN** (L6) **55336**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/11/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **110** (L18)

13.Total Certified Beds **110** (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
	110			
(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):

17. SURVEYOR SIGNATURE — Date :
Jessica Sellner, Unit Supervisor — 08/11/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 08/27/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/26/1983
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 09/22/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/10/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245263
August 27, 2015

Mr. Jon Braband, Administrator
Glencoe Regional Health Services
1805 Hennepin Avenue North
Glencoe, Minnesota 55336

Dear Mr. Braband:

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 July 31, 2015 the above facility is certified for or recommended for:

110 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 110 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 27, 2015

Mr. Jon Braband, Administrator
Glencoe Regional Health Services
1805 Hennepin Avenue North
Glencoe, Minnesota 55336

RE: Project Number S5263024

Dear Mr. Braband:

On July 14, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 26, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On August 11, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard extended survey, completed on June 26, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of . Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 26, 2015, effective July 31, 2015 and therefore remedies outlined in our letter to you dated July 14, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245263	A. Building B. Wing	8/11/2015

Name of Facility	Street Address, City, State, Zip Code
GLENCOE REGIONAL HEALTH SERVICES	1805 HENNEPIN AVENUE NORTH GLENCOE, MN 55336

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 **F0256** Reg. # **483.15(h)(5)** LSC	Correction Completed **07/31/2015**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **07/31/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **07/31/2015**
ID Prefix **F0492** Reg. # **483.75(b)** LSC	Correction Completed **07/31/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** JS/KJ	**Date:** 08/27/2015	**Signature of Surveyor:** 29249	**Date:** 08/11/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 6/26/2015

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: OPB6

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(L1) **245263**

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(L2) **909545400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GLENCOE REGIONAL HEALTH SERVICES**
(L4) **1805 HENNEPIN AVENUE NORTH**
(L5) **GLENCOE, MN** (L6) **55336**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/26/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **110** (L18)

13.Total Certified Beds **110** (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
	110			
(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):

17. SURVEYOR SIGNATURE Date :
Mary Rogers, HPR Social Work Specialist 07/28/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 08/06/2015 (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
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20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/26/1983
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 08/10/2015 Co.

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

Electronically delivered

July 14, 2015

Mr. Jon Braband, Administrator
Glencoe Regional Health Services
1805 Hennepin Avenue North
Glencoe, Minnesota 55336

RE: Project Number S5263024

Dear Mr. Braband:

On June 26, 2015, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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:

Jessica Sellner, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7365 Fax: (320)223-7365

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 August 5, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 26, 2015 (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 December 26, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: 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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245263	A. BUILDING _____ B. WING _____	06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENCOE REGIONAL HEALTH SERVICES	1805 HENNEPIN AVENUE NORTH GLENCOE, MN 55336

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 256 SS=D	483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS The facility must provide adequate and comfortable lighting levels in all areas. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure adequate lighting levels were maintained for 1 of 1 resident (R37) reviewed with concerns about comfortable lighting levels in their room. Findings include: During interview on 6/23/15, at 10:16 a.m. R37 stated the window in her room allowed too much light in at night because there was a street light outside the window, as well as a parking lot which had bright light from cars going by at night. R37 stated she had complained to staff who put a mattress pad over the window, however, the	F 256	It is the intent of Glencoe Regional Health Services LTC facility to provide adequate and comfortable lighting levels for our residents. On Monday June 29, 2015, the Director of Environmental Services met with resident (R37). The unacceptable mattress pad used as a window covering was removed. The Director talked with the resident about different options to reduce the light from night car traffic and from the parking lot light. They decided on adding an approved darkening curtain. On Monday, June 29, 2015, the Director installed an	7/31/15

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

Electronically Signed | 07/28/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245263	A. BUILDING _____ B. WING _____	06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENCOE REGIONAL HEALTH SERVICES	1805 HENNEPIN AVENUE NORTH GLENCOE, MN 55336

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F 256	Continued From page 1 mattress pad did not block out all the light. During interview and observation of R37's room on 6/26/15, at 1:30 p.m. with environmental services director (ES) and the vice president of long term care (VP) they both verified a mattress pad had been placed over R37's window and was not an appropriate solution to her lighting concerns. The mattress pad was draped over half the window surface and allowed light to shine through. A street lamp for the long-term care parking lot was observed located directly outside R37's window. The VP stated staff should have filled out a maintenance request so environmental services could have properly installed something on the windows in R37's room, and stated all nursing staff had access to file electronic maintenance requests through the computer system. During interview on 6/26/15, at 1:50 p.m. nursing assistant (NA)-E stated R37 had the mattress pad over her window for, "Quite a while," and was unsure if the mattress pad had been put up to eliminate light or a draft, as a nursing staff member had put it up for her. NA-E stated there should have been a maintenance slip filled out for R37's concern. A policy for maintenance requests was requested, none was provided.	F 256	expansion rod and a darkening curtain in addition to the resident's regular curtain. This option allows the resident to shield the light as needed. The Director followed up with the resident one week later and there were no issues. The resident expressed satisfaction with her curtains. The Director of Environmental Services implemented a system to insure that requests made by residents, family members and staff are received and completed in a timely manner. The pager system will be used when an incident or request needs immediate attention. Other non-urgent requests will be submitted to the Director via email. By September 1, 2015, the housekeeping/laundry requests will be submitted via the electronic requestor system. This is the same system we use for maintenance and information technology requests. The requests and completion of requests will be tracked in this software system. The Director wrote a policy and procedure regarding environmental services requests. Staff education to the department heads will be completed on July 28, 2015. Education to the front line staff will be completed in August at the nursing, dietary, activities and maintenance department meetings. The Director of Environmental Services will conduct monthly audits of window treatments and privacy curtains for three months or until compliance is met. During the monthly walk through, the Director will ensure that only approved curtains are	

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F 256	Continued From page 2	F 256	being used and that they are in good clean condition. The Director will report the audit results to the QAPI committee. Submitted for Jon Braband, President & CEO	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure medical justification for the ongoing use of an indwelling catheter was assessed for 1 of 2 residents (R29) reviewed for indwelling catheter use. Findings include: R29 was admitted to the facility, according to the undated face sheet on 8/19/13. R29's quarterly Minimum Data Set (MDS) dated 5/14/15, identified R29 was continent of bowel and bladder, had an indwelling catheter,required supervision of one staff for transfers, and	F 315	A complete audit was done by Director of Nursing on all active residents with a Foley catheter to verify a supporting diagnosis. For resident (R29) a voiding trial was done and R29 was referred to urology. R29 was seen by the urologist on July 2, 2015 with the urologist dictating R29 "has long term retention". Diagnosis noted by the urologist "Urinary retention with incomplete bladder emptying. Leave Foley in long term and change about every 6 weeks."	7/31/15

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F 315	Continued From page 3 extensive assistance of one staff for toileting. R29's care area assessment (CAA) dated 6/26/15, indicated R29 had an indwelling Foley catheter since 2010, for incomplete bladder emptying, and the catheter was changed in the clinic due to urethral meatus atrophy. R29's care plan dated 5/27/15, indicated an indwelling urinary catheter with a history of urinary tract infections (UTIs) and incomplete bladder emptying, with a goal of having no UTIs was identified. The care plan further indicated R29 was extensive assistance of one staff for transfers and could reposition independently. A urology consultation report dated 1/4/11, indicated R29 had urinary retention likely due to deconditioning. The recommendation comments indicated if the resident became more mobile a voiding trial would be warranted. R29's medical record lacked any further documentation as to whether a voiding trial had ever been attempted for R29, or if urology was consulted after her admission to long-term care to evaluate whether ongoing use of the catheter was warranted. Review of R29's labwork indicated the resident was treated with antibiotics for a urinary tract infection in 4/15. During observation on 6/26/15, at 2:34 p.m. R29 was observed in her recliner chair asleep. A catheter bag was secured underneath her wheelchair, with light yellow urine present in the tubing. During interview on 6/26/15, at 9:28 a.m. nursing assistant (NA)-D stated R29 had an indwelling	F 315	The Bowel and Bladder Assessment Policy & Procedure was updated, including the following statement "Residents requiring an indwelling catheter will be identified and current condition requiring the catheter will be documented. An indwelling catheter for which continuing use is not medically justified is discontinued as soon as clinically warranted. Services will then be provided to restore or improve normal bladder function to the extent possible, after the removal of the catheter." A Bowel & Bladder record will be initiated on the day of admission, readmission, quarterly, annually, and if a significant change occurs as stated in the GRHS Bowel & Bladder Assessment Policy & Procedure. The wing nurse will review the data collection and complete the Bowel/Bladder Assessment. Evaluation of medical justification for indwelling catheter use will be completed at the time the Bowel/Bladder Assessment is being done. Changes were made to the Electronic Charting System listing acceptable diagnoses/conditions for Foley catheter use. The DON in-serviced licensed staff on the updated policy and procedure on July 14, 2015. Education included the facility process for caring for residents with catheters, assessment, supporting diagnosis for indwelling catheter use, and care plan. The MDS Coordinator or designee will	

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F 315	Continued From page 4 catheter that she cared for daily by ensuring the drainage bag was in place in the morning and the bag was emptied at the start and end of her shift. During interview on 6/26/15, at 2:28 p.m. the director of nursing (DON) stated she was unable to provide information on the ongoing justification for the catheter. During interview on 6/26/15, at approximately 2:30 p.m. registered nurse (RN)-D indicated R29 had seen the urologist in the past and had the catheter since 2010, prior to her admission to long-term care. RN-D stated R29 had not been back to the urologist since 2011, according to the facility's records as well as the lack of additional documentation related to ongoing justification for the catheter. RN-D stated she would have assumed R29's primary physician would have said something if R29 should have a trial without the catheter. During interview on 6/26/15, at 2:50 p.m. R29 stated she was unsure why she had the catheter in place. During interview on 6/26/15, at 2:55 p.m. NA-F stated R29 was not difficult to transfer and could sometimes get on the toilet herself for bowel movements. Licensed practical nurse (LPN)-A was present during the interview and stated R29 had never had a voiding trial that he was aware of to see if the catheter could be removed. The facility policy, titled Bowel and Bladder Assessments dated 5/15, indicated residents who require a catheter will be identified and the current condition requiring the catheter use will be documented.	F 315	audit all new residents who are admitted with a Foley catheter for 3 months for completion and adherence to facility policy. DON will meet with the MDS Coordinator weekly to review audits for 3 months or until compliance is met. Submitted for Jon Braband, President & CEO	

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F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess falls, and consistently implement interventions to reduce the risk of falls and injury for 1 of 2 residents (R78) reviewed with multiple falls. Findings include: R78's quarterly Minimum Data Set (MDS) dated 3/28/15, identified R78 was cognitively intact, independent with ambulation, transfers, toileting, mobility, and required staff assistance with personal hygiene and dressing. R78's balance test indicated the resident was steady from seated to standing, and that R78, although unstable, was able to stabilize without assistance when turning direction while walking or transferring from surface to surface. R78's care plan dated 4/6/15, indicated the resident had diagnoses including alcohol dementia which included chronic confusion and memory loss related to alcoholic encephalopathy and alcohol induced dementia. The care plan indicated R78 had potential for injury related to	F 323	Resident (R78) received an order for Occupational Therapy (OT) to evaluate and treat environmental safety, and fall risk. R78 received an order for Speech Therapy (ST) on 6/30/15 regarding cognition and communication training. The resident's plan of care was revised based on OT and ST assessment findings as well as with additional interventions specific to R78. In addition, the attending physician ordered Neuropsychiatric testing on 7/8/15. The Falls Prevention and Protection Assessing Fall Risk Policy was updated to include an automatic physical and occupational therapy referral to screen resident after every fall that occurs. Licensed staff was in-serviced on changes made to the Falls policy on 7/14/15. Mandatory fall prevention staff education was held May 27 & June 2, 2015. Follow-up training for brain injuries will also be completed in the near future. A consultant will be on site to assess the	7/31/15

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F 323	Continued From page 6 falls, and the goals included the resident would have no injury from falls this quarter. The staff were instructed to encourage R78 to call for help, provide non skid foot wear, and ensure the resident used the 4 wheeled walker assistive device with which the resident could ambulate independently. During observation on 6/24/15, at 3:46 p.m. R78 was sitting in his room in the lounge chair with his feet elevated. There was a non slip mat on the floor in front of the chair, and the 4 wheeled walker was turned sideways in front and to the left side of him. During another observation on 6/25/15, at 7:42 a.m. R78 was observed in his room walking around with the door to the hallway open. The resident was not using his walker. R78 was observed to pull his pants down, and several staff walked by the room, however did not intervene or offer R78 assistance. R78 continued to walk around his room with his pants pulled down past his hips, and walked into the bathroom. Registered nurse (RN)-D walked into the room to talk with R78's roommate. R78 came out of the bathroom, still without his walker, and was struggling to get his pants pulled up however, RN-D did not offer assistance or direct R78 to use his walker. At 7:52 a.m. family member (FM)-A entered the room and assisted R78 to change his shirt and helped him pull his pants up. Review of R78's Incident Reports from January to June 2015, indicated the resident had experienced a number of falls since January 2015. The following information was found on fall summary documents regarding the assessment of the falls, and new interventions put into place to prevent further falls: 2/18/15- R78 had a fall in his room and received	F 323	facility's Falls Prevention Program. The Falls Prevention Team nurse leader will ensure completion of therapy referral after every fall. The Falls Prevention Team will review the Fall Incident and Investigation report on every fall when the Falls Prevention Team meets biweekly. This will include review of documentation to make sure root cause of fall was identified and interventions implemented are effective for the resident. The DON will monitor for 3 months. All falls are tracked, trended, and analyzed to determine failed or new interventions. The Director of Nursing will bring the results of the fall analysis to the QAPI meeting. Submitted for Jon Braband, President & CEO	

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a skin tear on his right hand ring finger, had bruised the right palm and middle ring finger, and complained of pain in the right shoulder, his back, and the top of his head. The assessment of the fall indicated the resident was exiting the bathroom, stumbled, and tried to catch himself on the edge of the door. The interventions included educating R78 on safe transfer technique, to use gripper socks or shoes when transferring, and having explained to the resident the importance of calling for help.
2/20/15- R78 had a fall in his room when he was walking to the bathroom and slipped and fell, the resident had complained of pain in both shoulders. The facility indicated the resident was educated on use of call light, was encouraged to use the call light, and the call light was clipped to his pants. In addition, R78 had also been seen by physical therapy (PT) on 2/10/15, with instruction to staff that the resident must use a 2 wheeled walker for all ambulation for safety.

3/11/15- R78 was in his room and staff was notified by R78's roommate the resident had fallen. The resident was found laying next to his recliner and he'd stated he'd lost his footing. A fall assessment indicated the resident had been wearing nonskid footwear, and was referred to PT for evaluation of falls. There was no indication in the assessment if the resident had been using his walker, or if the walker was near him when he had fallen.

PT progress notes indicated R78 had been seen by PT on 3/16/15, and PT had given direction for the patient to use a 4 wheeled walker for ambulation and transfers. The notes indicated R78 had been trained in safety techniques with the brakes and the seat on the walker, and staff

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were to ensure the resident used the 4 wheeled walker instead of the 2 wheeled walker.
4/21/15- R78 was found in his room face down on the floor with the top part of his head under his roommate's bed. The resident stated he was trying to get to his walker so he could go to the bathroom but had tripped and fallen. The report indicated the resident had complaints of pain in his left side, was sent to the hospital for evaluation where it was determined he'd fractured 2 ribs. The intervention for this fall was to continue to observe, instruction for the resident on fall prevention, explaining to resident importance of call light use, and initiation of hourly rounding by staff. The progress notes also indicated R78's family had requested the facility move the roommate's bed to a different location, which the facility did. There was no indication in the falls assessment of investigation as to where the walker had been located in the room prior to the fall, or when the last time staff had checked on R78 in order to ensure the walker was near the resident.
5/24/15- R78 fell in his room, and the assessment of the fall indicated the "possible cause" of the fall was the resident was not using his walker, and had slipped on the floor due to having taken off his gripper slippers. The resident had a small bump on the top of his head, and the facility educated the resident on using the call light, educated on safe transfer technique, educated resident to call for staff assistance, and to get up slowly and get balance before walking. The falls assessment did not identify where the walker was in the room, and if it was near the resident so it was available for use. Another PT assessment was requested.
6/10/15- R78 had gone outside by himself to water the flowers and had fallen. The resident

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F 323	Continued From page 9 complained of right wrist pain, was sent to the emergency room, and was found to have a fracture of the right wrist. The facility had again educated the resident on safe transfer technique and assistive device use, encouraged him to use the call light to request staff assistance, had discussed whether R78 would benefit from a TABs (type of electronic motion) alarm, and therapy had been notified to place a sign on the patio door that instructed R78 to ask for assistance when going outside. The falls assessment did not indicate whether R78 had been using the walker at the time of the fall. 6/12/15- R78 was found on floor in his room lying sideways with his head pushed on back of the recliner, and had no injury. The assessment of the fall indicated the possible cause was the resident was exhausted and weak from walking long distances from the dining room back to his room. The facility educated the resident on safe transfer technique, reminded resident to use seated walker, utilize the seat as needed for rest periods, and PT and OT collaborated to assess whether the resident should be a one assist with wheelchair to follow. The falls assessment did not indicate if the resident was using his walker or if it was nearby available for use. 6/14/15- R78 fell in his room, and the fall assessment indicated the resident stated he was transferring from the recliner to the bathroom and was in a hurry. The resident sustained a abrasion to the right side of his head. The facility educated the resident to use his call light for staff assistance, and to use the walker for all transfers. The falls assessment did not indicate if the resident was using the walker, or if it was nearby available for use. During an interview on 6/24/15, at 3:40 p.m.	F 323		

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RN-B stated R78 needed stand-by-assist while ambulating because of his poor judgement, and due to his compliance issues with consistent use of his walker, "I prefer to have stand-by-assist."

During interview on 6/24/15, at 5:27 p.m. NA (nursing assistant)-B stated R78 needed staff assistance because he is unsteady on his feet and is prone to falling, however often forgets to ask for assistance. NA-B stated staff should be checking on R78 often to ensure he is not transferring on his own and is using the walker.

During interview on 6/24/15, at 5:45 p.m. the facility's vice president (VP) and director of nursing (DON) were interviewed regarding fall interventions for R78. They stated R78 was on significant fluid restrictions, but was non-compliant, which resulted in a potassium imbalance, impacting his falls. They stated the facility's fall committee had determined the root cause of R78's falls as unsteady gait and the inability to remember to use his walker, and the fall interventions implemented included: a non-slip rug in front of his recliner, staff assistance to retrieve beverages as needed, hourly rounding for three days after multiple falls occurred in a single week, and evaluation of his resident room to ensure a clear pathway from his recliner to the bathroom.

During interview on 6/24/15, at 6:03 p.m. NA-A stated R78 was very independent, and staff needed to remind him to use his walker. NA-A stated staff should be checking on him frequently, however, stated there was no specific timeframe established for checking on him.

During interview on 6/25/15, at 7:33 a.m. NA-C

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stated R78 transferred himself independently, however, staff still checks on him about every 1/2 hour.

During interview on 6/25/15, at 7:44 a.m. RN-D stated R78 was very independent and doesn't use his call light. RN-D stated she will try to walk next to R78, however, she is not sure if the resident is required to be supervised with walking or not and stated she just uses her "judgement" regarding walking with R78.

During an interview on 6/25/15, at 7:52 a.m. R78 said, "I'm okay. I can do it myself. I dont need any help. I know I can fall but I can do it myself."

During interview on 6/25/15, at 3:09 p.m. RN-A stated the facility staff needed to remind R78 to use his walker on an hourly basis, and often the resident will say he doesn't need it. RN-A stated despite the reminders and re-education to use the walker, "Nine times out of ten, he's probably not using it [the walker], or not using it correctly... He can't comprehend to remember that. He'll carry something on it... He likes to set the coffee cup on the seat ..."

A follow up group interview was conducted on 6/26/15, at 10:34 a.m., with VP, DON and director of occupational therpay (DOT). DOT stated all residents in the facility received a general screening for physical therapy, occupational therapy, and speech therapy needs on a quarterly basis, by any one of the therapy disciplines. DOT stated R78 received a therapy screening on 2/17/15, after a fall, which led to an evaluation and treatment by physical therapy to address a decline in his balance testing score, and by the

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F 323	Continued From page 12 end of his physical therapy treatment, R78 was reported as independent with ambulation as long as he was using the 4 wheeled walker. DOT, DON and VP stated all employees were responsible for ensuring R78 was using his walker and had it available and nearby. DOT stated R78 worked with therapy again on 4/27/15, in relation to concerns of pain, and R78 continued to require the four-wheeled walker and was able to demonstrate safe use of his walker. On 6/17/15, physical therapy began working with R78 due to multiple falls, and DOT stated at this time his balance testing was showing he was a fall risk and his endurance had declined. DOT, DON and VP stated R78's fluid overload had likely begun to impact his breathing and endurance, and the consulting pharmacist had reviewed R78's medication regimen for any concerns which may have contributed to his falls, with no resulting recommendations for change. The facility policy titled Falls Prevention and Protection Assessing Fall Risk dated 3/2013, indicated all residents will be assessed for risk of falling by a licensed nurse. If a resident is at risk for falls, the facility should be observing the resident walking or attempting to self transfer, assist resident to a safe area if gait is unsteady, monitor patient and environment for safety every hour, offer assistance to the bathroom at mealtime, at bedtime, upon awakening, and every 2-3 hours throughout shift, and ensure call light and frequently used items are within reach.	F 323		
F 492 SS=D	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and	F 492		7/31/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245263	A. BUILDING _____ B. WING _____	06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENCOE REGIONAL HEALTH SERVICES	1805 HENNEPIN AVENUE NORTH GLENCOE, MN 55336

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F 492	Continued From page 13 local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 residents (R70) who requested a demand bill was not charged while the determination decision was pending. Findings include: R70 was admitted to the facility on 1/10/15. R70's medicare denial letter, dated 1/10/15, indicated family desired to have their bill submitted to the intermediary for a Medicare decision. During interview on 6/26/15, at 8:45 a.m. the business office manager indicated she had billed R70's family for services the end of January and family paid the bill in full on 2/9/15, however, the fiscal intermediary had not made a determination until 5/14/15. The business office manager indicated she was not aware an appeal had been requested until after the bill had gone out and family had paid for the services. A policy was requested regarding demand bills, none was provided.	F 492	The account for resident (R70) was reviewed on 6/25/15 to verify collection of private payment corresponded to the Medicare determination on the demand bill. On July 8, 2015 the DON, MDS Coordinator, LTC Bookkeeper, and Social Worker met to review and update Medicare Part A Denial Policy & Procedure. The Medicare Part A Denial Policy & Procedure was updated to include when a resident or responsible party has chosen the appeal option, the MDS Coordinator will route to the business office within 72 hours. Upon receipt of the appeal, the business office shall follow the steps to submit to Medicare and ensure resident not billed for services until Medicare findings are received. The DON, MDS Coordinator, LTC Bookkeeper, and Social Worker have been updated on the changes to the Medicare Part A Denial Policy & Procedure. In the case that a "Demand Bill" is requested in the next year, the MDS Coordinator and LTC Bookkeeper will complete a checklist/audit that certifies that the appropriate procedures were followed. The DON, MDS Coordinator,	

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F 492	Continued From page 14	F 492	LTC Bookkeeper, and Social Worker will meet weekly for 3 months or until compliance is met to audit all "demand bills". This is to ensure that charges, billing, and ongoing treatments are in compliance with the facility's policies on "Demand Bills". Submitted for Jon Braband, President & CEO	

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	245263	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/23/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENCOE REGIONAL HEALTH SERVICES	**1805 HENNEPIN AVENUE NORTH GLENCOE, MN 55336**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on September 19, 2014. At the time of this survey, Glencoe Regional Health Services C & NC was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. Glencoe Regional Health Services C & NC was constructed in 1984, with one building addition constructed in 1995. Both buildings are one-story in height, have no basement, are fully fire sprinkler protected and were determined to be of Type I(332) construction. The facility has an automatic fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility is separated from both a hospital and a senior apartment building, by complying two-hour fire wall assemblies. The facility has a capacity of 110 beds and had a census of 98 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET as evidenced by:	K 000		

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

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
July 14, 2015

Mr. Jon Braband, Administrator
Glencoe Regional Health Services
1805 Hennepin Avenue North
Glencoe, Minnesota 55336

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5263024

Dear Mr. Braband:

The above facility was surveyed on June 22, 2015 through June 26, 2015 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, Health Regulation 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.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Jessica Sellner at Telephone: (320)223-7365.

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,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00351	A. BUILDING: _____ B. WING _____	06/26/2015

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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: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On June 22nd, 23rd, 24th, 25th and 26th, 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess falls, and consistently implement interventions to reduce the risk of falls and injury for 1 of 2 residents (R78) reviewed with multiple falls. Findings include: R78's quarterly Minimum Data Set (MDS) dated 3/28/15, identified R78 was cognitively intact, independent with ambulation, transfers, toileting, mobility, and required staff assistance with	2 830	Corrected	7/31/15

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2 830	Continued From page 3 personal hygiene and dressing. R78's balance test indicated the resident was steady from seated to standing, and that R78, although unstable, was able to stabilize without assistance when turning direction while walking or transferring from surface to surface. R78's care plan dated 4/6/15, indicated the resident had diagnoses including alcohol dementia which included chronic confusion and memory loss related to alcoholic encephalopathy and alcohol induced dementia. The care plan indicated R78 had potential for injury related to falls, and the goals included the resident would have no injury from falls this quarter. The staff were instructed to encourage R78 to call for help, provide non skid foot wear, and ensure the resident used the 4 wheeled walker assistive device with which the resident could ambulate independently. During observation on 6/24/15, at 3:46 p.m. R78 was sitting in his room in the lounge chair with his feet elevated. There was a non slip mat on the floor in front of the chair, and the 4 wheeled walker was turned sideways in front and to the left side of him. During another observation on 6/25/15, at 7:42 a.m. R78 was observed in his room walking around with the door to the hallway open. The resident was not using his walker. R78 was observed to pull his pants down, and several staff walked by the room, however did not intervene or offer R78 assistance. R78 continued to walk around his room with his pants pulled down past his hips, and walked into the bathroom. Registered nurse (RN)-D walked into the room to talk with R78's roommate. R78 came out of the bathroom, still without his walker, and was struggling to get his pants pulled up however,	2 830		

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2 830	Continued From page 4 RN-D did not offer assistance or direct R78 to use his walker. At 7:52 a.m. family member (FM)-A entered the room and assisted R78 to change his shirt and helped him pull his pants up. Review of R78's Incident Reports from January to June 2015, indicated the resident had experienced a number of falls since January 2015. The following information was found on fall summary documents regarding the assessment of the falls, and new interventions put into place to prevent further falls: 2/18/15- R78 had a fall in his room and received a skin tear on his right hand ring finger, had bruised the right palm and middle ring finger, and complained of pain in the right shoulder, his back, and the top of his head. The assessment of the fall indicated the resident was exiting the bathroom, stumbled, and tried to catch himself on the edge of the door. The interventions included educating R78 on safe transfer technique, to use gripper socks or shoes when transferring, and having explained to the resident the importance of calling for help. 2/20/15- R78 had a fall in his room when he was walking to the bathroom and slipped and fell, the resident had complained of pain in both shoulders. The facility indicated the resident was educated on use of call light, was encouraged to use the call light, and the call light was clipped to his pants. In addition, R78 had also been seen by physical therapy (PT) on 2/10/15, with instruction to staff that the resident must use a 2 wheeled walker for all ambulation for safety. 3/11/15- R78 was in his room and staff was notified by R78's roommate the resident had fallen. The resident was found laying next to his recliner and he'd stated he'd lost his footing. A fall assessment indicated the resident had been wearing nonskid footwear, and was referred to PT	2 830		

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2 830	Continued From page 5 for evaluation of falls. There was no indication in the assessment if the resident had been using his walker, or if the walker was near him when he had fallen. PT progress notes indicated R78 had been seen by PT on 3/16/15, and PT had given direction for the patient to use a 4 wheeled walker for ambulation and transfers. The notes indicated R78 had been trained in safety techniques with the brakes and the seat on the walker, and staff were to ensure the resident used the 4 wheeled walker instead of the 2 wheeled walker. 4/21/15- R78 was found in his room face down on the floor with the top part of his head under his roommate's bed. The resident stated he was trying to get to his walker so he could go to the bathroom but had tripped and fallen. The report indicated the resident had complaints of pain in his left side, was sent to the hospital for evaluation where it was determined he'd fractured 2 ribs. The intervention for this fall was to continue to observe, instruction for the resident on fall prevention, explaining to resident importance of call light use, and initiation of hourly rounding by staff. The progress notes also indicated R78's family had requested the facility move the roommate's bed to a different location, which the facility did. There was no indication in the falls assessment of investigation as to where the walker had been located in the room prior to the fall, or when the last time staff had checked on R78 in order to ensure the walker was near the resident. 5/24/15- R78 fell in his room, and the assessment of the fall indicated the "possible cause" of the fall was the resident was not using his walker, and had slipped on the floor due to having taken off his gripper slippers. The resident had a small bump on the top of his head, and the facility	2 830		

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2 830	Continued From page 6 educated the resident on using the call light, educated on safe transfer technique, educated resident to call for staff assistance, and to get up slowly and get balance before walking. The falls assessment did not identify where the walker was in the room, and if it was near the resident so it was available for use. Another PT assessment was requested. 6/10/15- R78 had gone outside by himself to water the flowers and had fallen. The resident complained of right wrist pain, was sent to the emergency room, and was found to have a fracture of the right wrist. The facility had again educated the resident on safe transfer technique and assistive device use, encouraged him to use the call light to request staff assistance, had discussed whether R78 would benefit from a TABs (type of electronic motion) alarm, and therapy had been notified to place a sign on the patio door that instructed R78 to ask for assistance when going outside. The falls assessment did not indicate whether R78 had been using the walker at the time of the fall. 6/12/15- R78 was found on floor in his room lying sideways with his head pushed on back of the recliner, and had no injury. The assessment of the fall indicated the possible cause was the resident was exhausted and weak from walking long distances from the dining room back to his room. The facility educated the resident on safe transfer technique, reminded resident to use seated walker, utilize the seat as needed for rest periods, and PT and OT collaborated to assess whether the resident should be a one assist with wheelchair to follow. The falls assessment did not indicate if the resident was using his walker or if it was nearby available for use. 6/14/15- R78 fell in his room, and the fall assessment indicated the resident stated he was transferring from the recliner to the bathroom and	2 830		

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2 830	Continued From page 7 was in a hurry. The resident sustained a abrasion to the right side of his head. The facility educated the resident to use his call light for staff assistance, and to use the walker for all transfers. The falls assessment did not indicate if the resident was using the walker, or if it was nearby available for use. During an interview on 6/24/15, at 3:40 p.m. RN-B stated R78 needed stand-by-assist while ambulating because of his poor judgement, and due to his compliance issues with consistent use of his walker, "I prefer to have stand-by-assist." During interview on 6/24/15, at 5:27 p.m. NA (nursing assistant)-B stated R78 needed staff assistance because he is unsteady on his feet and is prone to falling, however often forgets to ask for assistance. NA-B stated staff should be checking on R78 often to ensure he is not transferring on his own and is using the walker. During interview on 6/24/15, at 5:45 p.m. the facility's vice president (VP) and director of nursing (DON) were interviewed regarding fall interventions for R78. They stated R78 was on significant fluid restrictions, but was non-compliant, which resulted in a potassium imbalance, impacting his falls. They stated the facility's fall committee had determined the root cause of R78's falls as unsteady gait and the inability to remember to use his walker, and the fall interventions implemented included: a non-slip rug in front of his recliner, staff assistance to retrieve beverages as needed, hourly rounding for three days after multiple falls occurred in a single week, and evaluation of his resident room to ensure a clear pathway from his recliner to the bathroom.	2 830		

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	00351	A. BUILDING: _____ B. WING _____	06/26/2015

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2 830	Continued From page 8 During interview on 6/24/15, at 6:03 p.m. NA-A stated R78 was very independent, and staff needed to remind him to use his walker. NA-A stated staff should be checking on him frequently, however, stated there was no specific timeframe established for checking on him. During interview on 6/25/15, at 7:33 a.m. NA-C stated R78 transferred himself independently, however, staff still checks on him about every 1/2 hour. During interview on 6/25/15, at 7:44 a.m. RN-D stated R78 was very independent and doesn't use his call light. RN-D stated she will try to walk next to R78, however, she is not sure if the resident is required to be supervised with walking or not and stated she just uses her "judgement" regarding walking with R78. During an interview on 6/25/15, at 7:52 a.m. R78 said, "I'm okay. I can do it myself. I dont need any help. I know I can fall but I can do it myself." During interview on 6/25/15, at 3:09 p.m. RN-A stated the facility staff needed to remind R78 to use his walker on an hourly basis, and often the resident will say he doesn't need it. RN-A stated despite the reminders and re-education to use the walker, "Nine times out of ten, he's probably not using it [the walker], or not using it correctly... He can't comprehend to remember that. He'll carry something on it... He likes to set the coffee cup on the seat ..." A follow up group interview was conducted on 6/26/15, at 10:34 a.m., with VP, DON and director of occupational therpay (DOT). DOT stated all residents in the facility received a general	2 830		

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2 830	Continued From page 9 screening for physical therapy, occupational therapy, and speech therapy needs on a quarterly basis, by any one of the therapy disciplines. DOT stated R78 received a therapy screening on 2/17/15, after a fall, which led to an evaluation and treatment by physical therapy to address a decline in his balance testing score, and by the end of his physical therapy treatment, R78 was reported as independent with ambulation as long as he was using the 4 wheeled walker. DOT, DON and VP stated all employees were responsible for ensuring R78 was using his walker and had it available and nearby. DOT stated R78 worked with therapy again on 4/27/15, in relation to concerns of pain, and R78 continued to require the four-wheeled walker and was able to demonstrate safe use of his walker. On 6/17/15, physical therapy began working with R78 due to multiple falls, and DOT stated at this time his balance testing was showing he was a fall risk and his endurance had declined. DOT, DON and VP stated R78's fluid overload had likely begun to impact his breathing and endurance, and the consulting pharmacist had reviewed R78's medication regimen for any concerns which may have contributed to his falls, with no resulting recommendations for change. The facility policy titled Falls Prevention and Protection Assessing Fall Risk dated 3/2013, indicated all residents will be assessed for risk of falling by a licensed nurse. If a resident is at risk for falls, the facility should be observing the resident walking or attempting to self transfer, assist resident to a safe area if gait is unsteady, monitor patient and environment for safety every hour, offer assistance to the bathroom at mealtime, at bedtime, upon awakening, and every 2-3 hours throughout shift, and ensure call light and frequently used items are within reach.	2 830		

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2 830	Continued From page 10 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and revice policies and procedures related to fall risk assessments, monitoring and care, and could provide staff education related to fall prevention and interventions. The director of nursing or designee could develop an audit tool to ensure appropriate care is provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure medical justification for the ongoing use of an indwelling	2 910	Corrected	7/31/15

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2 910	Continued From page 11 catheter was assessed for 1 of 2 residents (R29) reviewed for indwelling catheter use. Findings include: R29 was admitted to the facility, according to the undated face sheet on 8/19/13. R29's quarterly Minimum Data Set (MDS) dated 5/14/15, identified R29 was continent of bowel and bladder, had an indwelling catheter,required supervision of one staff for transfers, and extensive assistance of one staff for toileting. R29's care area assessment (CAA) dated 6/26/15, indicated R29 had an indwelling Foley catheter since 2010, for incomplete bladder emptying, and the catheter was changed in the clinic due to urethral meatus atrophy. R29's care plan dated 5/27/15, indicated an indwelling urinary catheter with a history of urinary tract infections (UTIs) and incomplete bladder emptying, with a goal of having no UTIs was identified. The care plan further indicated R29 was extensive assistance of one staff for transfers and could reposition independently. A urology consultation report dated 1/4/11, indicated R29 had urinary retention likely due to deconditioning. The recommendation comments indicated if the resident became more mobile a voiding trial would be warranted. R29's medical record lacked any further documentation as to whether a voiding trial had ever been attempted for R29, or if urology was consulted after her admission to long-term care to evaluate whether ongoing use of the catheter was warranted. Review of R29's labwork indicated the resident	2 910		

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2 910	Continued From page 12 was treated with antibiotics for a urinary tract infection in 4/15. During observation on 6/26/15, at 2:34 p.m. R29 was observed in her recliner chair asleep. A catheter bag was secured underneath her wheelchair, with light yellow urine present in the tubing. During interview on 6/26/15, at 9:28 a.m. nursing assistant (NA)-D stated R29 had an indwelling catheter that she cared for daily by ensuring the drainage bag was in place in the morning and the bag was emptied at the start and end of her shift. During interview on 6/26/15, at 2:28 p.m. the director of nursing (DON) stated she was unable to provide information on the ongoing justification for the catheter. During interview on 6/26/15, at approximately 2:30 p.m. registered nurse (RN)-D indicated R29 had seen the urologist in the past and had the catheter since 2010, prior to her admission to long-term care. RN-D stated R29 had not been back to the urologist since 2011, according to the facility's records as well as the lack of additional documentation related to ongoing justification for the catheter. RN-D stated she would have assumed R29's primary physician would have said something if R29 should have a trial without the catheter. During interview on 6/26/15, at 2:50 p.m. R29 stated she was unsure why she had the catheter in place. During interview on 6/26/15, at 2:55 p.m. NA-F stated R29 was not difficult to transfer and could sometimes get on the toilet herself for bowel	2 910		

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2 910	Continued From page 13 movements. Licensed practical nurse (LPN)-A was present during the interview and stated R29 had never had a voiding trial that he was aware of to see if the catheter could be removed. The facility policy, titled Bowel and Bladder Assessments dated 5/15, indicated residents who require a catheter will be identified and the current condition requiring the catheter use will be documented. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents with indwelling catheters to assure they are medically necessary. The director of nursing or designee, could review and/or revise facility policies and procedures related to residents admitted with indwelling catheters or residents who have indwelling catheters to ensure the medical necessity of the catheters are evaluated and addressed within the medical record. Random audits could be conducted to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
21670	MN Rule 4658.1405 A.B.C.D. Resident Units The following items must be provided for each resident: A. A bed of proper size and height for the convenience of the resident, a clean, comfortable mattress, and clean bedding, appropriate for the weather and resident's comfort, that are in good condition. Each bed must have a clean bedspread. A moisture-proof mattress or mattress cover must be provided for all residents confined to bed and for other beds as necessary.	21670		7/31/15

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21670	Continued From page 14 Rollaway type beds, cots, or folding beds must not be used. B. A chair or place for the resident to sit other than the bed. C. A place adjacent or near the bed to store personal possessions, such as a bedside table with a drawer. D. Clean bath linens provided daily or more often as needed. E. A bed light conveniently located and of an intensity to meet the needs of the resident while in bed or in an adjacent chair This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure adequate lighting levels were maintained for 1 of 1 resident (R37) reviewed with concerns about comfortable lighting levels in their room. Findings include: During interview on 6/23/15, at 10:16 a.m. R37 stated the window in her room allowed too much light in at night because there was a street light outside the window, as well as a parking lot which had bright light from cars going by at night. R37 stated she had complained to staff who put a mattress pad over the window, however, the mattress pad did not block out all the light. During interview and observation of R37's room on 6/26/15, at 1:30 p.m. with environmental services director (ES) and the vice president of long term care (VP) they both verified a mattress pad had been placed over R37's window and was not an appropriate solution to her lighting	21670	Corrected	

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21670	Continued From page 15 concerns. The mattress pad was draped over half the window surface and allowed light to shine through. A street lamp for the long-term care parking lot was observed located directly outside R37's window. The VP stated staff should have filled out a maintenance request so environmental services could have properly installed something on the windows in R37's room, and stated all nursing staff had access to file electronic maintenance requests through the computer system. During interview on 6/26/15, at 1:50 p.m. nursing assistant (NA)-E stated R37 had the mattress pad over her window for, "Quite a while," and was unsure if the mattress pad had been put up to eliminate light or a draft, as a nursing staff member had put it up for her. NA-E stated there should have been a maintenance slip filled out for R37's concern. A policy for maintenance requests was requested, none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of comfortable lighting in resident rooms. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent and individual resident rooms to ensure comfortable lighting is maintained to the extent possible. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21670		