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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OYI6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00568

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245090**

2.STATE VENDOR OR MEDICAID NO.
(L2) **270543500**

3. NAME AND ADDRESS OF FACILITY
(L3) **PLEASANT MANOR INC**
(L4) **27 BRAND AVENUE**
(L5) **FARIBAULT, MN** (L6) **55021**

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 2/10/2014 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **65** (L18)

13.Total Certified Beds **65** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	65			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Elizabeth Nelson, HFE-NE II 03/12/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 05/07/2014 (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
01/21/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/01/2014
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5090

On 02/10/14, a Post Certification Revisit (PCR) was completed by the Department of Health. Based on the PCR, it has been determined that the facility had achieved substantial compliance pursuant to the 12/13/13 standard survey, effective 01/17/14. Refer to the CMS 2567B for both health and life safety code.

Effective 01/17/14, the facility is certified for 65 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5090

Electronically Delivered: May 7, 2014

Ms. Bonnie Campeau, Administrator
Pleasant Manor Inc
27 Brand Avenue
Faribault, Minnesota 55021

Dear Ms. Campeau:

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 Februrary 10, 2014 , the above facility is certified for:

65 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 65 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 about this electronic notice.

Sincerely,

Anne Kleppe

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

Protecting, Maintaining and Improving the Health of Minnesotans

March 12, 2014

Ms. Bonnie Campeau, Administrator
Pleasant Manor Inc
27 Brand Avenue
Faribault, Minnesota 55021

RE: Project Number S5090023, H5090026

Dear Ms. Campeau:

On January 3, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 23, 2011. 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 February 10, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) that included an investigation of complaint number H5090026, to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 23, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 17, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 23, 2013, effective February 10, 2014 and therefore remedies outlined in our letter to you dated January 3, 2014, will not be imposed.

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

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

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

Sincerely,

Mark Meath

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

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

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
245090	A. Building B. Wing	2/10/2014

Name of Facility	Street Address, City, State, Zip Code
PLEASANT MANOR INC	27 BRAND AVENUE FARIBAULT, MN 55021

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 **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **02/10/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **02/10/2014**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **02/10/2014**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **02/10/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **02/10/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **02/10/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GL/MM	03/12/2014	13603	02/10/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 12/13/2013

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: OYI6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00568

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245090**

2.STATE VENDOR OR MEDICAID NO.
(L2) **270543500**

3. NAME AND ADDRESS OF FACILITY
(L3) **PLEASANT MANOR INC**
(L4) **27 BRAND AVENUE**
(L5) **FARIBAULT, MN** (L6) **55021**

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 **12/13/2013** (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)
09/30

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

12.Total Facility Beds **65** (L18)

13.Total Certified Beds **65** (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
	65			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Tammy Alberts, HFE NE II — 01/22/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 01/28/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/21/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

CCN-245090

At the time of the standard survey and investigation of unsubstantiated complaint H5090025 completed December 13, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D) whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 3050 0001 9094 7345

January 3, 2014

Ms. Bonnie Campeau, Administrator
Pleasant Manor Inc
27 Brand Avenue
Faribault, Minnesota 55021

RE: Project Number S5090023

Dear Ms. Campeau:

On December 13, 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. In addition, at the time of the December 13, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5090025. 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. In addition, at the time of the December 13, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5090025 that was found to be unsubstantiated.

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>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:

Gayle Lantto, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 22, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

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

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 March 13, 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 June 13, 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

Anne Kleppe, Enforcement 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
	245090	A. BUILDING _____ B. WING _____	12/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR INC	27 BRAND AVENUE FARIBAULT, MN 55021

(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 POC will serve as your allegation of compliance upon the department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. In addition to the standard recertification survey, complaint H5090025 was investigated and was found unsubstantiated.	F 000	RECEIVED JAN 17 2014 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	POC accepted as submitted 1/22/14	

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

Lonnie Compleau | Adm | 1/16/14

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	12/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR INC	27 BRAND AVENUE FARIBAULT, MN 55021

(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 280	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility did not revise the care to ensure revision of the care plan for 1 of 3 residents (R32) reviewed for activities of daily living (ADL) and for 1 of 3 residents (R39) reviewed for weight loss. Findings include: R32 was observed on 12/10/13, at 9:23 a.m. The resident had no bottom teeth and a black substance was built up underneath her long fingernails. The following day the resident was observed seated in her room. Her were clenched closed and when she was asked if she could open her hands, and when she did so, a horrendous odor was emitted from the palms of her hands. Her finger nails were dirty with the black substance under them and the resident had no bottom teeth. On 12/12/13 at 8:39 a.m. R32 was observed to be eating whole pieces toast and had no bottom teeth in her mouth. On 12/12/13, at 1:00 p.m. R39 again was observed without bottom teeth. At 1:05 p.m., nursing assistant (NA)-C stated that R39 was dependent on staff to complete her ADLs and the resident did not really participate. She stated that the resident usually got a bath on Tuesdays, and nail care was completed during that time. The resident also required additional nail care, as she sometimes engaged in rectal digging and scratching at her skin and picking at sores. The NA said that although the resident	F 280	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: a. With respect to R32 a Dental Assessment was completed on 1/13/14. Speech therapy is working with resident. Care plan and Nursing Assistant assignment sheet updated to reflect current cares. b. Residents will continue to be assessed for their individual dental and oral needs upon admission, quarterly, with a significant change and as needed. Care plans will reviewed for individualized dental/ oral needs. c. DNS/designee will audit 3 residents per week for 4 weeks, then 2 residents per week x 8 weeks for oral/dental needs by observation and medical record review. d. With respect to R32 plan of care and care data sheet has been reviewed and updated to reflect nail care.	

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	245090	A. BUILDING _____ B. WING _____	12/13/2013

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F 280	Continued From page 2 had bottom dentures, she had not worn them for about six months. R32's Minimum Data Set (MDS) dated 10/1/13, indicated the resident required extensive assistance to perform personal hygiene tasks. R32's care plan 10/22/13 indicated that she wore bottom dentures and had the potential for alteration in skin integrity related to itching self resulting in scratches. No interventions were identified for keeping the resident's hands and nails clean and odor free. On 12/12/13 at 2:55 p.m. a registered nurse (RN)-A stated that it was her understanding that R32 did not wear her lower dentures. She stated that nail care should have been completed each morning and evening, and as needed. She verified these needs were not on the care plan and should have been. Care plan policy and procedure, undated, indicated, "Care plans must be comprehensive. All problems, needs and concerns identified through assessment or observation as well as anything we do for the resident that is not a normal part of the routine should be a part of the care plan. Quarterly, significant change and annual: each discipline should review the care plan and develop suggested changes prior to care conferences. The changes are discussed at the care conference, agreed upon and finalized by the care team. Changes to the resident's care that are not considered significant should be added to the care plan as the change occurs. These changes should be dated and communicated as needed."	F 280	e. DNS/designee will audit 3 residents per week for 4 weeks, then 1 resident per week x 8 weeks to ensure nail cares are completed. f. In respect to R39, resident has been discharged from the facility to home. g. Resident weights will be monitored per facility protocol. Residents will continue to be assessed for their individual nutrition needs upon admission, quarterly, with a significant change and as needed. Care plans are reviewed for individualized weight management / nutrition program and needs. h. DNS/Designee will audit resident's records for weight management and nutrition needs. Will audit 3 records per week for 4 weeks, then 2 resident's records for 8 weeks. This data will be shared at the next quality assurance meeting by the DNS/designee for input and further direction. F.DNS responsible for completion	1/17/14

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F 280	Continued From page 3	F 280		

R39 had weight loss of greater than 25 pounds in two months, however, this was not reflected on the resident's current care plan. Although dietary and nursing were aware of R39's weight loss and related the loss to lymphedema (abnormal fluid in the tissues), diuretic use and the resident's request for smaller portion meals was not identified on the care plan with relevant interventions or appropriate goals for weight loss such as weight loss parameters.

R39 was admitted to the facility in 8/3/13 following surgery for malignant lung cancer. R39 discharged from the facility on 11/11/13. R39's recorded weights were as follows: 8/4/13-202 pounds, 8/11/13-199.2, 8/25/13-189.6, 9/8/13-182.6, 9/29/13-182.2, 10/6/13-177, 10/13/13-174.2, and 11/10/13-169.2.

R39's care plan dated 8/21/13, identified R39 as having a nutritional problem and goals were to maintain admission weigh of 210 pounds with no signs or symptoms of malnutrition, and consuming at least 75% of at least three meals daily. The intervention indicated the resident needed "a calm, quiet setting at meal times with adequate eating time, provide foods high in protein to promote healing. Provide regular diet as orders. Monitor intake and record every meal."

A registered dietitian's (RD) notes dated 8/29/13 revealed, "Regular portions to large would like smaller portions...new admission. Initial nutritional assessment addressed. Visited resident.

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F 280	Continued From page 4 Recommendation made for small portions per resident request. Recheck weight per ? infection/67% intake. Weight change may be impacted by diuretic/lymphedema" (abnormal fluid in the tissues). A follow up note on 9/9/13, "Visited with resident and spoke with nursing regarding weight pattern. Resident is OK with weight, feels has less fluid. Is on diuretic and has had upper respiratory issues past month/on antibiotic. No dietary changes other than will ask dietary to give smaller breakfast portion per resident request." A subsequent note on 10/24/13, revealed an initial care conference was held and resident received a regular diet with small portions requested. "Consuming 100% of meals, up from last intake of 74%. Requests to eat meals in room. Has no difficulty chewing and swallowing. Has no concerns at this time. Present weight is 174# down 27.4# in 90 days. Continue on present plan and diet. Continue to monitor weight." On 12/11/13, at 1:54 p.m., registered nurse (RN)-A, stated she was familiar with R39 during her admission and indicated R39's "weight loss was related to diuretic use." On 12/12/13, at 4:00 p.m. the dietary manager stated she was familiar with resident and stated the resident wanted to lose weight so she could breathe better and requested small portions. The dietary manager further indicated the weight loss was also related to fluid loss from diuretic use and eating less. The dietary manager acknowledged this was not documented on the care plan. The consultant RD stated in an interview in	F 280		

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F 280	Continued From page 5 12/13/13 at 10:25 a.m. she was familiar with R39 who had wished to lose weight and was eating well although on smaller portion diet. The RD stated she had conversations with nursing regarding the residents weight loss and did not identify resident as being at nutritional risk due to good appetite/intakes, requested smaller portions, anticipated short stay and expected fluid loss due to diuretics. The undated Care Plan Policy and Procedure directed staff as follows: "Care plan must be interdisciplinary. The team will meet on a regular basis and discuss problems, needs and concerns of the resident. As a team, they will write goals, plans and intervention to help the resident deal with various issues. Care plans must be comprehensive. All problems, needs and concerns identified through assessment or observation as well as anything we do for the resident that is not a normal part of the routine should be a part of the care plan. Procedure: Quarterly, significant change and annual: 1. Each discipline should review the care plan and develop suggested changes prior to care conferences. The changes are discussed at care conference, agreed upon and finalized by the care team. 2. Changes to the resident's care that are not considered significant should be added to the care plan as the change occurs. These changes should be dated and communicated as needed. Write the problems, needs and concerns. Goals can be short or long term. Plan and interventions	F 280		

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F 280	Continued From page 6 are what staff do to help the resident reach his/her goals. Plans and interventions should be specific, saying what we plan to do, when we plan to do it and the frequency."	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a properly fitting wheelchair for 1 of 1 resident (R1) who was observed for poorly positioned in the wheelchair. Findings include: R1 was observed not provided a proper fitting wheel chair. Her feet did not reach the ground surface. Foot pedals were not attached to the wheelchair. R1 was chair bound. On 12/10/13, at 8:25 a.m. R1 was observed self-propelling down the hallway in a wheelchair using her upper extremities to manipulate the wheels. Her feet were two to three inches off the floor, and no foot pedals were in use on the chair. The following morning at 10:15 a.m. R1 was resting with her head down in the wheelchair, and again her feet did not touch the floor. At 10:25	F 309		

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F 309	Continued From page 7 a.m. the resident wheeled down the hallway using her arms to manipulate the wheels and with the assistance of the handrails to pull herself. During the observations, the resident was not wearing shoes. On 12/12/13, at 7:07 a.m. specially fitted shoes were observed under bedside stand in R1's room. No foot pedals were observed in the room. At 7:15 a.m. the resident was again observed up in the wheelchair and her feet were dangling. An approximate three-inch cushion was on the seat of the chair. An occupational therapist (O)-E stated R1 needed foot rests when interviewed on on 12/12/13, at 8:54 a.m. The therapist said the shoes under the night stand were "diabetic shoes" and that the resident's feet would still not reach the floor if she was wearing the shoes. O-E verified the resident had not had a wheel chair positioning consultation by the departments' staff. She thought perhaps the resident had lost weight because she sank down too far in the chair, making the chair too big for her size. The therapist stated sometimes residents in the long term care part of the facility were missed for such assessments, as therapy focus tended to be on transitional care. A Minimum Data Set (MDS) dated 10/22/13, revealed R1 was independent with wheelchair mobility. A nursing note dated 11/05/13, outlined a care conference meeting and indicated R1 was asked if she wanted foot pedals and she declined. A Rehabilitation Mobility Screen had been completed on 1/13/13, and it had been determined the resident was independent with wheel chair mobility, and an evaluation was not	F 309	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: With respect to R1, this resident is currently receiving Occupational Therapy for w/c positioning Residents will continue to be assessed for their individual positioning needs upon admission, quarterly, with a significant change and as needed. Care plans will reviewed for individualized positioning needs. Staff will receive re-education regarding positioning and care plan. DNS/Designee will audit 3 residents including medical record for positioning assessment and individualized care plans for 4 weeks and then 2 medical records for 8 weeks. The data will be shared at the next quality assurance meeting by the DNS/designee for input and further direction. DNS responsible	1/17/14

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F 309	Continued From page 8 indicated. The resident's diagnoses included edema (excess fluid in the tissues, commonly in the feet). A registered nurse (RN)-B explained in an interview on 12/12/13, at 2:55 p.m. that the cushion in R1's wheel chair had been exchanged with a cushion that was at least an inch smaller in depth. The RN also added that if the resident wore shoes, it also aided in wheelchair positioning. On 12/13/13 at 10:55 a.m. a nursing assistant (NA)-B stated she did not offer R1 foot rests. The NA felt the resident did not need to lift her feet because she was unable to reach the floor. On 12/13/13 at 11:15 a.m., the director of nursing (DON) stated therapists assessed residents upon admission and with each MDS assessment. She revealed there had been "trouble" since a change with the therapy provider in 2/13. The DON stated the MDS nurse now evaluated residents at the time of each each MDS assessment.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide appropriate	F 312		

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F 312	Continued From page 9 personal hygiene care for 1 of 3 residents (R32) who were reviewed for activities of daily living (ADL). R32 was observed on 12/10/13, at 9:23 a.m. The resident had no bottom teeth and a black substance was built up underneath her long fingernails. The following day the resident was observed seated in her room. Her were clenched closed and when she was asked if she could open her hands, and when she did so, a horrendous odor was emitted from the palms of her hands. Her finger nails were dirty with the black substance under them and the resident had no bottom teeth. On 12/12/13 at 8:39 a.m. R32 was observed to be eating whole pieces toast and had no bottom teeth in her mouth. On 12/12/13, at 1:00 p.m. R39 again was observed without bottom teeth. At 1:05 p.m., nursing assistant (NA)-C stated that R39 was dependent on staff to complete her ADLs and the resident did not really participate. She stated that the resident usually got a bath on Tuesdays, and nail care was completed during that time. The resident also required additional nail care, as she sometimes engaged in rectal digging and scratching at her skin and picking at sores. The NA said that although the resident had bottom dentures, she had not worn them for about six months. R32's Minimum Data Set (MDS) dated 10/1/13, indicated the resident required extensive assistance to perform personal hygiene tasks. R32's care plan 10/22/13 indicated that she wore bottom dentures and had the potential for alteration in skin integrity related to itching self	F 312	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: a. With respect to R32 a Dental Assessment was completed on 1/13/14. Speech therapy is working with resident. Care plan and Nursing Assistant assignment sheet updated to reflect current cares. b. Residents will continue to be assessed for their individual dental and oral needs upon admission, quarterly, with a significant change and as needed. Care plans will reviewed for individualized dental/ oral needs. c. DNS/designee will audit 3 residents per week for 4 weeks, then 2 residents per week x 8 weeks for oral/dental needs by observation and medical record review. d. With respect to R32 plan of care and care data sheet has been reviewed and updated to reflect nail care. e. DNS/designee will audit 3 residents per week for 4 weeks, then 1 resident per week	

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F 312	Continued From page 10 resulting in scratches. No interventions were identified for keeping the resident's hands and nails clean and odor free. On 12/12/13 at 2:55 p.m. a registered nurse (RN)-A stated that it was her understanding that R32 did not wear her lower dentures. She stated that nail care should have been completed each morning and evening, and as needed.	F 312	x 8 weeks to ensure nail cares are completed. f. In respect to R39, resident has been discharged from the facility to home. g. Resident weights will be monitored per facility protocol. Residents will continue to be assessed for their individual nutrition needs upon admission, quarterly, with a significant change and as needed. Care plans are reviewed for individualized weight management / nutrition program and needs. h. DNS/Designee will audit resident's records for weight management and nutrition needs. Will audit 3 records per week for 4 weeks, then 2 resident's records for 8 weeks. This data will be shared at the next quality assurance meeting by the DNS/designee for input and further direction. F.DNS responsible for completion	1/17/14
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 appropriately identify the need and risk of side rails for 1 of 3 residents (R31) in the sample who utilized side rails on the bed. Findings include: The facility did not identify the potential safety risk for half side rails utilized by R31. On 12/10/13, at 9:44 a.m. R31 was observed in bed with bilateral half side rails up on the bed. The Physical Device Evaluation 10/27/13,	F 323		

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F 323	Continued From page 11 indicated R31 needed grab bar on left side of bed, per therapy recommendation. The care plan 11/8/13, indicated R31 had a self-care performance/mobility deficit related to right shoulder reverse arthroplasty on 10/24/13, rotator cuff tear repair x 3 in history, dementia and weakness. The interventions included 1/2 side rails to bilateral sides of the bed to aide in bed mobility. The care plan also identified R31 at risk for falls related to dementia, unaware of limitations, self-transfer attempts and restlessness. R31's initial Minimum Data Set (MDS) dated 11/1/13, identified the resident as having moderate cognitive impairment and needing extensive assistance with bed mobility, transferring and walking. On 12/12/13, at 8:00 a.m. a nursing assistant (NA)-D stated R31 required the assistance of one staff and the rails for turning and repositioning and getting out of bed. NA-D further stated the resident was able to transfer self out of bed but was not safe to do so independently. On 12/12/13, at 2:15 p.m., registered nurse (RN)-A stated an assessment for the use of half side rails was not completed, as the resident was initially using a grab bar. The RN said an assessment should have been completed. The facility documentation guide dated 2/12 for assessment of Physical Restraint-Siderail/Physical Device Evaluation directed staff to complete an assessment "on admission, hospital return/readmission, quarterly, annually and with significant change, complete if resident has a physical restraint or potential	F 323	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: a. In respect to R 31, resident has been discharged from the facility to home b. Residents will continue to be assessed for need and use of assistive devices upon admission, quarterly, with a significant change and as needed. Care plans reviewed for assistive device use. Staff will receive re-education regarding side rail use and care plan. C.DNS/Designee will audit by observation and medical review for 2 residents with assistive devices for one month and then one resident for 8 weeks. The data will be shared at the next quality assurance meeting by the DNS/designee for input and further direction. DNS is responsible.	1/17/14

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F 323	Continued From page 12 physical restraint and complete with the first few hours of admission if applicable or when any new device is implemented."	F 323	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: The facility staffing coordinator received re-education on the procedure for updating staffing hours posting. Licensed staff will receive re-education on the policy/procedure of updating posted staffing hours. Executive director/ Designee will audit posted staffing hours 3 times weekly for 4 weeks then 2 times weekly for 8 weeks to ensure the proper staffing hours are posted. At next QAA meeting the committee will review the findings and determine the frequency and duration of the audits. Data will be reviewed/ discussed at monthly QA. The QA committee ill make decisions/ recommendations regarding any necessary follow up. Executive Director is responsible.	1/17/14
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced	F 356		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	12/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR INC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 13	F 356		

by:
Based on observation, interview and document review, the facility failed to post the actual hours worked per shift for nursing staff directly responsible for resident care and to post the correct schedule on 12/12/13. This had the potential to affect 65 residents and visitors of the facility.

Findings Include:

On 12/9/13, at 1:00 p.m. during the initial tour of the facility, the Pleasant Manor Daily Staffing was posted in the front hall adjacent to the west living room. The posted nursing hours did not provide actual hours worked by registered and licensed nurses responsible for providing direct resident care.

On 12/12/13, at 3:00 p.m. the posting hours was dated 12/11/13, and behind it was the schedule for 12/10/13. No other schedules were posted.

During an interview on 12/13/13, at 9:15 a.m. the staffing coordinator (SC-A) stated she used the form in the computer to complete the daily staffing assignment. She said she may have the wrong form. SC-A explained that on 12/12/13, she worked an evening shift and did not come to work until after 2:00 p.m. and reported directly to her unit. She stated she made the schedule for 12/12/13, on the day prior and placed it behind the current schedule, however, she verified the schedule was not at the posting site. SC-A went to her office and found the schedule for 12/12/13 on her desk. She explained she "mistakenly put out Tuesday's schedule instead of the schedule for Thursday."

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	245090	A. BUILDING _____ B. WING _____	12/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 356	Continued From page 14 Nurse Staffing Information Guidelines dated 12/11 directed the posting include nurse staffing hours on a daily basis in a format which includes: the facility name, current date, total number and actual hours worked by the following categories of nursing personnel; registered nurses, licensed practical nurses and certified nursing assistants. Review of the forms provided by the facility for 12/9/13 through 12/13/13, revealed the usual shifts licensed and unlicensed staff were scheduled to work, but did not identify the actual shift hours worked. On 12/13/13, at 10:30 a.m. the prior staffing coordinator (SC)-B stated the templates generated from the computer did provide actual hours but that page was not posted along with the other that listed usual hours. She further stated the director of nursing was ultimately responsible to post staffing hours when the staffing coordinator unable. SC-B also clarified the charge nurse was responsible for staff postings on the weekends.	F 356		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441		

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 441	Continued From page 15 (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement procedures to prevent the spread of infection during blood glucose monitoring for 1 of 1 resident (R5) whose blood glucose monitoring was observed. Findings include: The facility failed to ensure proper disinfecting was conducted for a shared glucometer unit.	F 441	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: The procedure was reviewed with the identified staff members on 12/12/13. Facility policy and procedure for disinfecting shared glucometer unit was reviewed with personnel directly responsible for performing glucometer testing. In respect to R5 the identified staff member was provided re-education regarding infection control practices. All staff received re-education on infection control principles related to glucose monitoring. DON or designee will audit staff performance for glucose monitoring and infection control principles for 2 staff a week for 4 weeks then 1 staff a week for 4 weeks. Data will be reviewed/ discussed at monthly QA. The QA committee will make decisions/ recommendations regarding any necessary follow up. DNS responsible.	1/17/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	12/13/2013

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F 441	Continued From page 16 On 12/12/13, at 7:45 a.m. a registered nurse (RN)-C was observed to test R5's blood sugar with a glucometer unit (device for determining concentration of glucose in blood). When RN-C was finished checking R5's blood sugar she opened a single antiseptic towelette (benzalkonium chloride 0.13 %) and wiped off the glucometer unit. RN-C then wrapped the glucometer unit with the towelette and left in contact with the glucometer for three minutes. RN-C then removed the glucometer form R5's room and placed on the north wing (west side) medication cart. On 12/13/13, at 10:00 a.m. a licensed practical nurse (LPN)-B stated that there was three residents who required periodic blood sugar checks from the from the glucometer. When interviewed on 12/12/13, at 3:50 p.m. the director of nursing (DON) stated staff were directed to clean glucometers using the Super Sani-Cloth which was effective against bloodborne pathogens and tuberculosis. The DON stated she had no information on the antiseptic towelette (benzalkonium chloride 0.13 %) that was used to clean the glucometer or was unaware of where the staff person had obtained it. The box containing the antiseptic towelettes indicated the purpose of the active ingredient (benzalkonium chloride 0.13 %) was for "antiseptic handwash." The policy for Cleaning and Disinfecting Blood Glucose Meters, undated, indicated, "It is ARWAY'S policy to advise healthcare professionals to clean or disinfect meters between each resident test to avoid cross-contamination issues. In the event that you	F 441		

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F 441	Continued From page 17 do not have bleach or your policies prohibit bleach being kept in the facility, you can recommend one of the following products as an alternative; Steris Coverage Spray HB or Sani Cloth Super or HB Germicidal Disposable Wipe."	F 441		

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	245090	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/11/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR INC	**27 BRAND AVENUE** **FARIBAULT, MN 55021**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Pleasant Manor Nursing Home 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. Pleasant Manor Nursing Home is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1963 and was determined to be of Type II(111) construction. In 1978, addition was constructed to the Northwest Wing that was determined to be of Type II(111) construction. In 1996, another addition was added to the Southeast Wing and was determined to be Type II (111). Because the original building and the 2 additions are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 65 beds and had a census of 65 at the time of the survey.	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.

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	245090	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/11/2013**

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K 000	Continued From page 1 The requirement at 42 CFR, Subpart 483.70(a) is MET. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 000		