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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: P2F0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00636

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245253**

2.STATE VENDOR OR MEDICAID NO.
(L2) **907455000**

3. NAME AND ADDRESS OF FACILITY
(L3) **CENTRACARE HEALTH PAYNESVILLE KORONIS**
(L4) **MANOR CC 200 FIRST STREET WEST**
(L5) **PAYNESVILLE, MN** (L6) **56362**

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 **03/27/2014** (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 **52** (L18)

13.Total Certified Beds **52** (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
	52			
(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 :
Tim Rhonemus, HFE NE II — 03/27/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 4/10/2014 (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
09/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/17/2014
(L33)

DETERMINATION APPROVAL

On 3/27/2014 the Minnesota Department of Health completed a Post Certification Revisit to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective 3/4/ 2014, the facility is certified for 52 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245253

April 11, 2014

Ms. Beverly Mueller, Administrator
Centracare Health Paynesville Koronis Manor Cc
200 First Street West
Paynesville, MN 56362

Dear Ms. Mueller:

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 3/4/2014, the above facility is certified for:

52 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 52 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
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 11, 2014

Ms. Beverly Mueller, Administrator
Centracare Health Paynesville Koronis Manor Cc
200 First Street West
Paynesville, Minnesota 56362

RE: Project Number S5253024

Dear Ms. Mueller:

On February 11, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 23, 2014. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On March 27, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 23, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 4, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 23, 2014, effective March 4, 2014 and therefore remedies outlined in our letter to you dated February 11, 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.

Sincerely,

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245253	A. Building B. Wing	3/27/2014

Name of Facility	Street Address, City, State, Zip Code
CENTRACARE HEALTH PAYNESVILLE KORONIS MANOR CC	200 FIRST STREET WEST PAYNESVILLE, MN 56362

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 **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **02/28/2014**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **02/20/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **02/21/2014**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **03/04/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/KJ	4/10/2014	20794	3/27/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/23/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: P2F0

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(L1) **245253**

2.STATE VENDOR OR MEDICAID NO.
(L2) **907455000**

3. NAME AND ADDRESS OF FACILITY
(L3) **CENTRACARE HEALTH PAYNESVILLE KORONIS**
(L4) **MANOR CC 200 FIRST STREET WEST**
(L5) **PAYNESVILLE, MN** (L6) **56362**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/23/2014** (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 **52** (L18)

13.Total Certified Beds **52** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
X 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: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	52			
(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 :
Bruce Melchert HFE NE II — 02/26/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 03/14/2014 (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
09/01/1987
(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

Page 2
Provider Number: 24-5253
Item 16 Continuation for CMS-1539

At the time of the standard survey completed January 23, 2014, the facility was not in substantial compliance and the most serious deficiencies were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. 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 # 7011 2000 0002 5143 8453

February 11, 2014

Ms. Beverly Mueller, Administrator
Centracare Health Paynesville Koronis Manor CC
200 First Street West
Paynesville, Minnesota 56362

RE: Project Number S5253024

Dear Ms. Mueller:

On January 23, 2014, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

<u>Informal Dispute Resolution</u> - 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:

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320) 223-7338
Fax: (320) 223-7348

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 March 4, 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 April 23, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 23, 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,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

CENTRACARE Health
Paynesville

200 West First Street | Paynesville, MN 56362
(320) 243-3767 phone | (800) 242-3767 toll-free
www.centracare.com

KORONIS MANOR CARE CENTER
Addendum to Plan of Correction
February 25, 2014

I. In reference to all cited tags, the completion date for the entire plan of correction is February 28, 2014.

II. **Tag 225: Investigate/Report Allegations/Individuals**

C. The Director of Nursing (D.O.N) is responsible to monitor compliance with policy, reporting to state agency on time and accurately all resident complaints on a daily basis.

III. **Tag 226: Develop/Implement abuse/neglect, policies**

C. The Director of Nursing (DON) is responsible to monitor compliance with policy, reporting accurately and on time on a daily basis.

IV: **Tag 282: Services by Qualified Persons / per care plan**

C. The charge nurse is responsible to monitor the accurate completion of cares as documented in care plan on a daily basis per shift.

V: **Tag 314: Treatment/SVCS to prevent / Heal Pressure Sores**

C. The charge nurse is responsible to monitor the completion of cares as documented in care plan on a daily basis per shift. DON will audit on a weekly basis, the re-positioning of residents and following of care plans per shift to alleviate pressure and avoid pressure ulcers.

Signature: Beverly Mueller Date: 2/26/2014
Beverly Mueller, LTCA

2/26/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245253	A. BUILDING _____ B. WING _____	01/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH PAYNESVILLE KORONIS MANOR CC	200 FIRST STREET WEST PAYNESVILLE, MN 56362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS A. NA-B was alerted to the resident complaints concerning her rude and rough treatment while caring for them. NA was required to complete a training module on appropriate care of the residents, "Superior Patient Experience" which was completed on January 24, 2014. In addition, the NA was assigned to 7 shifts of charge nurse oversight, whereby the NA and nurse conducted all shift's resident tasks together. The NA was open to all constructive remarks in reminding her to do her job slowly, without rushing and using a tone of voice that residents would find acceptable and not rude. The nurses reported that NA-B took their mentoring remarks well and made good progress with	

2/26/14 See addendum P7

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: LTCA — (X6) DATE: 2-20-14

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.

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	245253	A. BUILDING _____ B. WING _____	01/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH PAYNESVILLE KORONIS MANOR CC	200 FIRST STREET WEST PAYNESVILLE, MN 56362

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F 225	Continued From page 1 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 5 of 11 residents (R3, R35, R47, and R13) with complaints of abuse, neglect or mistreatment, received thorough investigations into each allegation, residents were protected during the investigations and the allegations were immediately reported to the administrator and state agency (SA). Findings include: R3 complained nursing assistant (NA)-B was "rough" with her; however, the facility did not complete a thorough investigation, protect residents during the investigation, or report the complaint to the SA. R3's facility face sheet indicated her diagnoses included generalized pain and Parkinson's disease. The admission Minimum Data Set (MDS) dated 12/24/13, indicated R3 was cognitively intact and required extensive assistance with most activities of daily living	F 225	toning her behavior by the end of the 1:1 training. Over the last four weeks, the Social Service Manager spoke to all residents involved at random intervals and there have been no new complaints of inappropriate staff behavior. NA-B notified the facility of her termination of employment as of March 12, 2014 to pursue her college education as a full time student. NA-X was alerted to the resident complaint of rude treatment. She also was required to complete the training module on appropriate care of residents, "Superior Patient Experience", which was completed on January 24, 2014. The NA apologized to this resident and is striving to bring a positive attitude and gentle, calm behavior to the residents each day. Over the last four weeks, the Social Service Manager spoke to all residents involved at random intervals and there have been no new complaints of in-appropriate behavior. NA-Y, NA-Z, NA-M were alerted to resident complaints of them being rude or hurrying them during the provision of cares. All three NA's apologized to the residents involved. The	

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F 225	Continued From page 2 (ADLs). During interview on 1/23/14, at 8:55 a.m. R3 reported the NA who cared for her the prior evening was "rough" when assisting her to the bathroom. R3 stated the NA pushed her in the wheelchair, into the bathroom and banged her knee against the toilet. R3 stated the NA was always rough with her and "whipped her legs into bed," which caused her pain. R3 did not want to identify the NA by name; however, she indicated that she had spoken with other staff and the facility social worker regarding her concern with the NA, but "nothing gets done," and the NA continued caring for her and continued "being rough." During interview on 1/23/14, at 9:15 a.m. NA-C confirmed R3 had complained to her about a NA who was "rough" with her, who she identified as NA-B. NA-C reported she forwarded R3's complaints to several charge nurses and she met with the director of nursing (DON) about NA-B being rough with residents. NA-C added, NA-B just "whips people into bed" and was very rude. NA-C stated, when she met with the DON she was told NA-B had a "military background" and was "just rough around the edges." During interview on 1/23/14, at 10:41 a.m. the DON confirmed she was aware of concerns of NA-B being "abrupt." The DON stated she had several meetings with NA-B and believed she just did not do a lot of small talk, or give a lot of "warm fuzzies." The DON stated she often received reports from day shift staff, indicating residents complained about their care after NA-B worked the evening or night shift with them. The DON was unable to provide documentation regarding	F 225	three NA's received re-training on policies and procedures of the role of a certified nursing assistant and the expectations of a professional manner and quality care here at the facility. At this time, all nursing assistants will be required to complete the module "Superior Patient Experience" as part of their annual training requirements to be completed by February 28, 2014. DON and Social Service will continue to monitor resident issues concerning staff actions while caring for the residents. B. Each shift nurse will report any complaints of inappropriate staff behavior during the care of residents to the administrator and DON and immediately to the State Agency (SA) as detailed by policy. Social Service will conduct random discussions with residents to identify or investigate any issues or their perception of unsatisfactory care given by the staff. During care conferences, charge nurse and Social Service will ask resident and families what their perception of care here at the facility is and if they feel they are safe and respected. Any issues will be immediately reported to	

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F 225	Continued From page 3 which residents had made these complaints, or evidence of meetings/re-education provided to NA-B in response to the complaints. The DON was also unable to provide evidence the complaints of rough treatment were reported to the SA. The DON indicated that social worker (SW)-A had spoken to R3 regarding "concerns with a staff member" several weeks ago; however, she believed the complaint was about staff in general and was not specific to NA-B. During interview on 1/23/14, at 11:00 a.m. SW-A stated an evening charge nurse had brought forward concerns regarding R3's complaint that staff were being too rough with her. SW-A provided documentation of her investigation, including an email dated 1/5/14, which revealed the following: "[R3] voiced concern to staff/ nursing and myself of overnight girls being too rough with her. When asked if she could tell me which staff member her comment was 'the one with the long hair.'... [R3] again enforced these same concerns with myself and her son present. I asked her what she meant by staff being too rough with her; she stated no patience and too rough. I reassured her I would address these concerns...." The investigation documentation dated 1/6/14, signed by SW-A noted, "SW interviewed resident on 1/6/14, and she is not able to give much details...." The investigation results noted the charge nurse "talked with the aide involved that fits the description and she denies maltreatment. Aide is instructed to apologize for making resident feel uncomfortable. Aide identified as [NA-B]. During interview able to tell her action taken and she was OK with that." The investigation lacked interviews with other residents and staff who may have witnessed the alleged mistreatment. SW-A stated this was not	F 225	administrator, DON and SA as stated by policy. C. On January 31, all nurses were required to attend a re-training session of the vulnerable adult policy, types of cases that warrant a VA report, to notify administrator and DON, the requirement to immediately file the report and investigate after the filing. At monthly, Quality Assurance (QA) Committee Meetings, the QA Coordinator will report a summary of VA reports filed, types of incident, resolution reported and if staff met all process/policy requirements for filing a VA report. Administrator and DON will monitor any patterns of complaint, design and implement a corrective action to resolve the pattern and report action and resolution to the QA Committee. D. The facility will monitor VA reports each month to identify facility patterns by type, staff member and time of day, review the result of follow-up investigations, and State response to each report filed. The facility will strive to have no patterns of in-appropriate care provided by individual staff, to have all VA reports filed immediately and to confirm that staff is	

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F 225	Continued From page 4 reported to the SA because she determined this was more of a "perception of feelings" versus "abuse." During interview on 1/23/14, at 12:05 p.m. licensed practical nurse (LPN)-A stated she had "heard" R3 did not like NA-B providing cares for her; however, she was not sure of any details. LPN-A stated she believed NA-B continued to provide cares to R3. On 1/23/14, at 2:15 p.m., registered nurse (RN)-Q and RN-S were interviewed. RN-Q, reported she had heard complaints regarding NA-B having a poor "bedside manner." RN-Q indicated she had informed the DON about these complaints. RN-S added that NA-B did not smile and some residents felt rushed at bed time, as though the NAs did not care about them. During a confidential interview on 1/23/14, at 2:20 p.m. an anonymous staff member reported R3 "freaked out" that morning when she mistook the identity of another staff member for NA-B. The anonymous staff person reported she had informed supervisors of the concerns she heard residents express regarding the evening and night staff being rough, or not responding to their requests in a timely fashion. Review of grievance reports revealed concerns of rude/rough treatment of R35 and neglect/rude treatment of R47 by facility employees; however these incidents were not thoroughly investigated or immediately reported to the administrator or SA. R35's undated care plan noted, "I have generalized pain R/T [related to] osteoarthrosis of	F 225	counseled on appropriate care and delivery of care to provide safety and respectful care to the residents. E. Final responsibility for compliance with reporting complaints of maltreatment according to policy remain with the Administrator and Director of Nursing. Corrective action is to be completed by February 28, 2014.	

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F 225	Continued From page 5 legs, knees, feet and back. I also have neuropathy and tremors in paralyzed side." During a confidential interview on 1/23/14, at 1:00 p.m. an anonymous staff member reported she overheard a nursing assistant, (NA)-X, speaking rudely and being rough toward R35, who indicated pain during cares. The anonymous staff member added, she shared her observations with a manager and filled out a concern form on R35's behalf. Review of a Suggestion, Concern or Grievance form dated 9/24/13, revealed a concern related to NA-X while helping R35 change her clothes. The form noted NA-X "rudely stated your leg is fine," while R35 was in pain. NA-X had a "very negative attitude" toward R35 and was "very impatient." R35's comments included, "This is what I hear every day." The investigation included the DON speaking to NA-X, who then agreed to have a more positive attitude. R47's MDS dated 9/19/13, indicated she required extensive assistance with toileting and associated tasks, such as perineal cares. Her most recent, undated care plan noted, "Change soiled clothing after each incontinent episode," and "Cleanse skin with soap and water after each incontinent episode." The facility Suggestion, Concern or Grievances form dated 11/18/13, alleged that on the night of 11/17/13, "[R47] was incontinent of bowel movement and put her call light on and the staff member told her 'you can do it yourself.' She also mentioned there is a girl on the evening shift that is rude to her and often refuses to help her stating she can do it herself." The follow-up	F 225		

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F 225	Continued From page 6 investigation included an interview with a caregiver, (C)-A, who worked with R47 the following morning, who confirmed R47 was covered with feces and dried feces was on the floor. The DON spoke with the NA-Y and NA-Z. She instructed NA-Y and NA-Z on proper care of incontinent stool and reminded them that their attitude was perceived as non-helpful and unkind by R47. No further interviews were completed with other residents or staff to discover if there were similar incidents of potential neglect or rude treatment. During interview on 1/23/14, at 1:45 p.m. the administrator and DON confirmed there was no further investigation or follow-up completed in relation to the allegations for R35 and R47. No other interviews were completed with residents or staff to determine whether there were similar incidents of rough/rude treatment or neglect. The DON could not recall whether the administrator was notified of the allegations and there was no documentation to suggest the incidents were reported to the SA. R13's had two bruises on her forehead, and alleged she received rough and rushed cares from nursing assistant (NA)-M. The facility failed to investigate the incident or report it to the SA. R13's Diagnosis/History face sheet (undated) indicated she had diagnoses of depression, weakness and pain. Her most recent quarterly MDS dated 11/20/13, indicated she was moderately cognitively impaired and required extensive assistance with transfers and toileting. Review of a Resident Incident Report dated 11/16/13, at 7:55 a.m. indicated R13 had a raised	F 225		

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F 225	Continued From page 7 bruise at her mid forehead, measuring 1.5 centimeter (cm) by 1.5 cm. There was also another bruise below this, to the right that was lighter in color, turning yellow, measuring 2.5 cm by 2.5 cm. The report indicated "Resident does not know how this bruise/injury occurred." The undated Resident Incident Follow-Up report noted, "Resident said when she stood up in the Bathroom this morning she bumped her head on the wall. She felt she was being rushed during a.m. cares- states 'all the young one hurry.'" The undated Post Incident Actions form indicated the facility spoke with the NA-M about taking time with R13 and that she did not like to be rushed. The undated Incident Investigation form revealed the care plan was reviewed and determined staff followed the care plan. The environment was reviewed and R13 had no changes in medical status. The investigation report noted R13 had no history of similar incidents or any other identified issues with the staff member involved. During interview on 1/23/14, at 1:30 p.m. SW-A reported that when she investigated the incident, NA-M indicated R13 did not hit her head during a transfer. SW-A then stated she thought the incident/bruising must have been an accident so she did not report it to the SA or investigate the incident any further. During interview on 1/23/14, at 1:45 p.m. R13 stated she received a bruise a few months prior on her head, when a unknown staff member was rough and fast while assisting her to stand. R13 indicated this lead to hitting her head against the wall.	F 225		

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F 225	Continued From page 8 During interview 1/23/14, at 2:00 p.m. DON stated she did not report the incident to the SA because she did not feel NA-M was truly being rough with the R13. No other interviews were completed with residents or staff to determine whether there were similar concerns of rough/rushed cares. There was no evidence of other incident/bruising reports having been reviewed for patterns. The facility Abuse Prevention and Vulnerable Adult Reporting Plan dated 1/12, instructed, "Each incident report will be followed with an internal investigation and when appropriate, reports will be made to [the SA] in accordance with state and federal laws... all alleged violations of abuse, neglect, mistreatment ...must be reported immediately to the administrator, DON, and the appropriate state agencies [SA]... The facts of the internal person/ incident and circumstances will be recorded on the facility incident report... Involved staff and residents will be interviewed as appropriate... If it is between an employee and resident, the employee may be suspended until investigation is completed...."	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced	F 226	483.13(c)DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES A. All residents cited (R3, R35, R47, and R13) have been interviewed by Social Service post survey and all reported complaints of maltreatment have been resolved. Social Service met with all residents at weekly intervals since survey and inquired about current	

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F 226	Continued From page 9 by: Based on interview and document review, the facility failed to implement abuse prohibition policies and procedures to ensure 5 of 11 residents (R3, R35, R47, and R13) with complaints of abuse, neglect or mistreatment, received thorough investigations into each allegation, residents were protected during the investigations and the allegations were immediately reported to the administrator and state agency (SA). Findings include: The facility Abuse Prevention and Vulnerable Adult Reporting Plan dated 1/12, instructed, "Each incident report will be followed with an internal investigation and when appropriate, reports will be made to [the SA] in accordance with state and federal laws... all alleged violations of abuse, neglect, mistreatment or misappropriation of property must be reported immediately to the administrator, DON, and the appropriate state agencies [SA]... The facts of the internal person/ incident and circumstances will be recorded on the facility incident report... Involved staff and residents will be interviewed as appropriate... If it is between an employee and resident, the employee may be suspended until investigation is completed...." R3 complained nursing assistant (NA)-B was "rough" with her; however, the facility did not complete a thorough investigation, protect residents during the investigation, or report the complaint to the SA as per facility policy. R3's facility face sheet indicated her diagnoses included generalized pain and Parkinson's	F 226	resident's perception of cares delivered by staff. No new complaints have been documented. Residents report that care offered is respectful, and patient. Social Service will continue to have random meetings with residents to assure no new issues have surfaced. B. On January 31, all nurses were required to attend a re-training session of the vulnerable adult report policy, types of cases that warrant a VA report, to notify administrator and DON, the requirement to immediately file the report and investigate after the filing. Since January 23, 2014 the facility has submitted seven VA reports correctly and according to policy timeline. All seven reports' disposition have been received and files closed. C. Each incident is discussed at daily inter-disciplinary management meeting. Discussion of incident, accuracy of following policy, notification of administrator and DON and submission timeline met are reviewed. D. Summary of VA reports submitted and procedure followed will be presented to QA Committee each month to	

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F 226	Continued From page 10 disease. The admission Minimum Data Set (MDS) dated 12/24/13, indicated R3 was cognitively intact and required extensive assistance with most activities of daily living (ADLs). During interview on 1/23/14, at 8:55 a.m. R3 reported the NA who cared for her the prior evening was "rough" when assisting her to the bathroom. R3 stated the NA pushed her in the wheelchair, into the bathroom and banged her knee against the toilet. R3 stated the NA was always rough with her and "whipped her legs into bed," which caused her pain. R3 did not want to identify the NA by name; however, she indicated that she had spoken with other staff and the facility social worker regarding her concern with the NA, but "nothing gets done," and the NA continued caring for her and continued "being rough." During interview on 1/23/14, at 9:15 a.m. NA-C confirmed R3 had complained to her about a NA who was "rough" with her, who she identified as NA-B. NA-C reported she forwarded R3's complaints to several charge nurses and she met with the director of nursing (DON) about NA-B being rough with residents. NA-C added, NA-B just "whips people into bed" and was very rude. NA-C stated, when she met with the DON she was told NA-B had a "military background" and was "just rough around the edges." During interview on 1/23/14, at 10:41 a.m. the DON confirmed she was aware of concerns of NA-B being "abrupt." The DON stated she had several meetings with NA-B and believed she just did not do a lot of small talk, or give a lot of "warm fuzzies." The DON stated she often received	F 226	monitor compliance with policy and resolution of all patterns noted. If patterns emerge, re-training of staff to VA submission process will be scheduled. Nurses who do not comply with the VA policy will receive a disciplinary action slip and if not remedied, the nurse could face suspension. E. Final responsibility for compliance to policy for reporting incidents of abuse/ neglect remain with the Administrator and Director of Nursing. Corrective action is to be completed by February 20, 2014.	

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(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 226	Continued From page 11 reports from day shift staff, indicating residents complained about their care after NA-B worked the evening or night shift with them. The DON was unable to provide documentation regarding which residents had made these complaints, or evidence of meetings/re-education provided to NA-B in response to the complaints. The DON was also unable to provide evidence the complaints of rough treatment were reported to the SA. The DON indicated that social worker (SW)-A had spoken to R3 regarding "concerns with a staff member" several weeks ago; however, she believed the complaint was about staff in general and was not specific to NA-B. During interview on 1/23/14, at 11:00 a.m. SW-A stated an evening charge nurse had brought forward concerns regarding R3's complaint that staff were being too rough with her. SW-A provided documentation of her investigation, including an email dated 1/5/14, which revealed the following: "[R3] voiced concern to staff/ nursing and myself of overnight girls being too rough with her. When asked if she could tell me which staff member her comment was 'the one with the long hair.'... [R3] again enforced these same concerns with myself and her son present. I asked her what she meant by staff being too rough with her; she stated no patience and too rough. I reassured her I would address these concerns..." The investigation documentation dated 1/6/14, signed by SW-A noted, "SW interviewed resident on 1/6/14, and she is not able to give much details...." The investigation results noted the charge nurse "talked with the aide involved that fits the description and she denies maltreatment. Aide is instructed to apologize for making resident feel uncomfortable. Aide identified as [NA-B]. During interview able to	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245253	A. BUILDING _____ B. WING _____	01/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH PAYNESVILLE KORONIS MANOR CC	200 FIRST STREET WEST PAYNESVILLE, MN 56362

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F 226	Continued From page 12 tell her action taken and she was OK with that." The investigation lacked interviews with other residents and staff who may have witnessed the alleged mistreatment. SW-A stated this was not reported to the SA because she determined this was more of a "perception of feelings" versus "abuse." During interview on 1/23/14, at 12:05 p.m. licensed practical nurse (LPN)-A stated she had "heard" R3 did not like NA-B providing cares for her; however, she was not sure of any details. LPN-A stated she believed NA-B continued to provide cares to R3. On 1/23/14, at 2:15 p.m., registered nurse (RN)-Q and RN-S were interviewed. RN-Q, reported she had heard complaints regarding NA-B having a poor "bedside manner." RN-Q indicated she had informed the DON about these complaints. RN-S added that NA-B did not smile and some residents felt rushed at bed time, as though the NA-B did not care about them. During a confidential interview on 1/23/14, at 2:20 p.m. a anonymous staff member reported R3 "freaked out" that morning when she mistook the identity of another staff member for NA-B. The anonymous staff member reported she had informed supervisors of the concerns she heard residents express regarding the evening and night staff being rough, or not responding to their requests in a timely fashion. Review of grievance reports revealed concerns of rude/rough treatment of R35 and neglect/rude treatment of R47 by facility employees; however the facility did not follow their abuse prohibition policies related to thorough investigations and immediate reporting to the administrator or SA.	F 226		

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F 226	Continued From page 13 Review of R35's undated care plan noted, "I have generalized pain R/T [related to] osteoarthrosis of legs, knees, feet and back. I also have neuropathy and tremors in paralyzed side." R35's undated care plan noted, "I have generalized pain R/T [related to] osteoarthrosis of legs, knees, feet and back. I also have neuropathy and tremors in paralyzed side." During a confidential interview on 1/23/14, at 1:00 p.m. an anonymous staff member, reported she overheard a nursing assistant, (NA)-X, speaking rudely and being rough toward R35, who indicated pain during cares. The anonymous staff member added, she shared her observations with a manager and filled out a concern form on R35's behalf. Review of a Suggestion, Concern or Grievance form dated 9/24/13, revealed a concern related to NA-X to R35 while helping change her clothes. The form noted NA-X "rudely stated your leg is fine," while R35 was in pain... NA-X had a "very negative attitude" toward R35 and was "very impatient." R35's comments included, "This is what I hear every day." The investigation included the DON speaking to NA-X, who then agreed to have a more positive attitude. R47's MDS dated 9/19/13, indicated she required extensive assistance with toileting and associated tasks, such as perineal cares. Her most recent, undated care plan noted, "Change soiled clothing after each incontinent episode," and "Cleanse skin with soap and water after each incontinent episode."	F 226		

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CENTRACARE HEALTH PAYNESVILLE KORONIS MANOR CC	200 FIRST STREET WEST PAYNESVILLE, MN 56362

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F 226	Continued From page 14 A Suggestion, Concern or Grievances form dated 11/18/13, alleged that on the night of 11/17/13, "[R47] was incontinent of bowel movement and put her call light on and the staff member told her 'you can do it yourself.' She also mentioned there is a girl on the evening shift that is rude to her and often refuses to help her stating she can do it herself." The follow-up investigation included an interview with a caregiver, CA-A, the following morning who confirmed R47 was covered with feces and dried feces was on the floor. The DON spoke with the NA-Y and NA-Z. She instructed NA-Y and NA-Z proper care of incontinent stool and reminded them that their attitude was perceived as non-helpful and unkind by R47. No further interviews were done with other residents or staff to discover if there were similar incidents of potential neglect or rude treatment. During interview on 1/23/14, at 1:45 p.m. the administrator and DON confirmed there was no further investigation or follow-up completed in relation to the allegations for R35 and R47. No other interviews were done with residents or staff to determine whether there were similar incidents of rough/rude treatment or neglect. The DON could not recall whether the administrator was notified of the allegations and there was no documentation to suggest the incidents were reported to the SA. R13's had a bruise on her forehead, she reported allegations of rough and rushed cares. The facility failed to further investigate the incident and report it to the SA as directed in the facility's abuse prohibition policy. R13's Diagnosis/History face sheet indicated she had diagnoses of depression, weakness and	F 226		

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F 226	Continued From page 15 pain. Her most recent quarterly MDS dated 11/20/13, indicated she was moderately cognitively impaired and required extensive assistance with transfers and toileting. Review of a Resident Incident Report dated 11/16/13, at 7:55 a.m. indicated R13 had a raised bruise at her mid forehead, measuring 1.5 centimeter (cm) by 1.5 cm. There was also another bruise below this, to the right that was lighter in color, turning yellow, measuring 2.5 cm by 2.5 cm. The report indicated "Resident does not know how this bruise/injury occurred." The undated Resident Incident Follow-Up report noted, "Resident said when she stood up in the Bathroom this morning she bumped her head on the wall. She felt she was being rushed during a.m. cares- states 'all the young one hurry. '" The undated Post Incident Actions form indicated the facility spoke with the nursing assistant (NA)-M about taking time with R13 and that she did not like to be rushed. The undated Incident Investigation form revealed the care plan was reviewed and determined staff followed the care plan. The environment was reviewed and R13 had no changes in medical status. The investigation report noted R13 had no history of similar incidents or any other identified issues with NA-M. During interview on 1/23/14, at 1:30 p.m. social worker (SW)-A reported that when she investigated the incident, NA-M indicated R13 did not hit her head during a transfer. SW-A then stated she thought the incident/bruising must have been an accident so she did not report it to	F 226		

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F 226	Continued From page 16 the SA or investigate the incident any further. During interview on 1/23/14, at 1:45 p.m. R13 stated she received a bruise a few months prior on her head, when a unknown staff member was rough and fast while assisting her to stand. R13 indicated this lead to hitting her head against the wall. During interview 1/23/14, at 2:00 p.m. DON stated she did not report the incident to the SA because she did not feel NA-M was truly being rough with the R13. No other interviews were completed with residents or staff to determine whether there were similar concerns of rough/rushed cares. There was no evidence of other incident/bruising reports having been reviewed for patterns.	F 226		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely repositioning as directed in the plan of care, for 1 of 4 residents (R30) reviewed for pressure ulcers. Findings include: The current care plan dated 1/23/14, identified R30 was at risk for skin breakdown due to bowel incontinence, dependency on staff for	F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN PLAN A. The charge nurse reviewed and modified the care plan to reflect current issues and needs of this one resident (R30). The charge nurse then met with all staff across all three shifts to detail changes in the care plan and what care would now be required for this resident. The charge nurse then placed specific tasks and directions in the CNA's charting files for them to implement, follow and chart on while providing care for the resident. The open area reported at time of survey has been treated,	

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F 282	Continued From page 17 mobility/transfers and had a diagnoses of diabetes, hemiparesis, and traumatic brain injury. The care plan directed staff to turn or reposition R30 side-to-side, every two hours while in his bed or chair and keep him off of his back. During constant observation of R30 on 1/23/14, from 7:56 a.m. to 10:34 a.m., 2 hours 38 minutes, R30 remained seated in his wheelchair without being repositioned. Upon interview, at 10:34 a.m., NA-D stated R30 was supposed to be repositioned and toileted every two hours. NA-D verified it had been over 2.5 hours since staff had repositioned him. NA-D confirmed R30 had an open area on his buttock and had been complaining of his bottom hurting while seated. During interview on 1/23/14, at 11:03 a.m. registered nurse (RN)-A verified R30 was to be repositioned every two hours and was not to be lying on his back due to the open area on his buttock and his high risk for the development of pressure ulcers.	F 282	subject to repositioning and is healing (about 90% healed) as of February 18, 2014. All staff is aware of this resident's risk for pressure sores and monitoring of positioning schedules is in place to prevent a future area of breakdown. B. The facility has started a quarterly review of all resident's care plans for appropriateness, accuracy and if it reflects current patient status. All 52 care plans will be reviewed, updated, and/or modified by an interdisciplinary team by March 21, 2014. Staff will be notified of all changes to care plans and CNA charting screens will be changed to reflect new care plan changes.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 314	C. Charge nurse on each shift will identify all changes in care plans to the staff at start of each shift. DON will be responsible to audit charting for proper completion of cares as required by resident care plan. Nursing will request a PT/OT screening for any resident that appears to be uncomfortable sitting in their wheelchair for measures to alleviate pressure and avoid ulcers. During toileting, bathing or dressing, the CNA's will report to charge nurse any signs of pressure noted on resident's skin. A summary of skin issues will be reported	

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	245253	A. BUILDING _____ B. WING _____	01/23/2014

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F 314	Continued From page 18 review, the facility failed to demonstrate timely repositioning to minimize the risk for pressure ulcers and monitor existing pressure ulcers, for 1 of 4 residents (R30) reviewed for pressure ulcers. Findings include: R30's quarterly Minimum Data Set (MDS) dated 11/22/13, identified him as moderately cognitively impaired and at risk for the development of pressure ulcers. The MDS revealed R30 required extensive assistance with mobility and transfers. During interview on 1/22/14, at 1:10 p.m. R30 stated it "hurts to sit," referencing his bottom was sore. Nursing assistant (NA)-D, also present at the time of interview, added that R30 had told her about his buttock pain earlier in the day and she reported it to the nurse. At 1:15 p.m. NA-D was observed to assist R30 into his bed, lying on his back. R30 remained on his back until 2:30 p.m. During continuous observation of R30 on 1/23/14, from 7:56 a.m. to 10:34 a.m., 2 hours 38 minutes, R30 remained seated in his wheelchair without being repositioned. At 10:34 a.m., NA-D stated R30 was supposed to be repositioned and toileted every two hours and it had been over 2.5 hours since staff had repositioned him. NA-D confirmed R30 had an open area on his buttock and had been complaining of his bottom hurting while seated. At 10:35 a.m., R30's bottom was observed with an open area to the right side of the right gluteal crease, which appeared to be approximately one by two centimeters (cm). Review of the progress notes indicated a departmental note written by registered nurse (RN)-A on 1/22/14, at 11:54 a.m. identified R30 had moisture associated skin irritation to the right side of his gluteal crease. Calmoseptine (an ointment used as a moisture barrier for skin irritations) was to be applied as per consultation with the facility's certified wound specialist	F 314	each month at Quality Assurance Committee and any patterns resulting in pressure areas will be addressed and resolved in a timely manner. D. Care plans will be reviewed monthly for accuracy, change of resident status and need for modifications. Staff will be alerted to all changes to care plans at the start of each shift. Changes to care plans will also be recorded on the report room's white board for all staff to review at the start of each shift. Each month at the Quality Assurance Committee, the QA Coordinator will report summary of all pressure ulcers. if care plans were followed, status of reported ulcers (current or resolved) and if the care plan requires additional modification. The Coordinator will also monitor the details of all newly identified pressure areas to determine if corrective action is required to avoid future pressure areas. E. Final responsibility for compliance with resident's care plan at time of delivering care services remains with the Director of Nursing. Corrective action is to be completed by February 21, 2014. 483.25(c)TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	

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	245253	A. BUILDING _____ B. WING _____	01/23/2014

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CENTRACARE HEALTH PAYNESVILLE KORONIS MANOR CC	200 FIRST STREET WEST PAYNESVILLE, MN 56362

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F 314	Continued From page 19 (CWS). There were no additional notes about the pressure ulcer. The care plan dated 1/23/14, identified R30 was at risk for skin breakdown due to bowel incontinence, dependency on staff for mobility/transfers and his diagnoses of diabetes, hemiparesis, cardiovascular insufficiency and traumatic brain injury. The care plan directed staff to turn or reposition R30 side-to-side, every two hours while in his bed or chair and keep him off of his back. During interview on 1/23/14, at 11:03 a.m. registered nurse (RN)-A stated she observed the open area to R30's buttock the day prior and it appeared more like a moisture area rather than a pressure area but was unsure. RN-A verified they had not taken any measurements of the new, open area or any monitoring of the wound. RN-A stated R30 should be repositioned every two hours and was not to be lying on his back due to the open area on his buttock and was at high risk for the development of pressure ulcers. There was no indication the facility has assessed R30 new pressure ulcers, even though R30 was identified he was at risk for the development of pressure ulcer. Also, the care plan interventions to prevent pressure ulcers from developing were not implemented.	F 314	A. Each shift, for this resident (R30) the Charge Nurse is required to confirm with staff their understanding of the current care plan. As of January 25, this resident, R30, was re-positioned every 2 hours moving side to side while in bed. He was positioned correctly in wheelchair to travel to dining room for meals and then returned to his bed and positioned on his side. His open area is resolving and he is comfortable while up in his chair. Nursing has adjusted his care plan and the staff will continue to monitor him for re-positioning and keeping him off his back to prevent future areas of pressure. B. All residents will be assessed for potential pressure areas at times of dressing, bathing and toileting and care plans will be adjusted to reflect need for re-positioning. All changes in care plans will be discussed with staff at shift change and documented on report room's white board to alert staff of changes to the care plan. C. Charge Nurse on each shift will monitor compliance with all care plan changes and document all re-positioning activity, resident tolerance, and if pressure areas are not resolving. If open areas occur, the Charge Nurse will seek a physician order for resident to be evaluated for treatment by the	

CONTINUATION OF F314
facility wound nurse. Staff will comply with all wound nurse recommendations.
D. Each month at the Quality Assurance Committee, the QA Coordinator will report a summary of all current pressure areas, corrective action in place and staff compliance with all repositioning directives.
Staff will receive re-training in repositioning techniques and how to avoid pressure areas as part of their annual facility training to be completed by March 17, 2014.
E. Final responsibility for compliance with appropriate treatment of pressure ulcer remains with the Director of Nursing.
Corrective action is to be completed by March ~~17~~ 4, 2014.

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

F5253023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245253	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/24/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRACARE HEALTH PAYNESVILLE KORON	**200 FIRST STREET WEST PAYNESVILLE, MN 56362**

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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Paynesville Area Health Care System - Koronis Manor 01 Main Building was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

The Paynesville Area Health Care System - Koronis Manor was constructed at 2 different times. The original building was constructed in 1965, is 1-story and was determined to be of Type II(000) construction. In 1989 a 1-story addition with a partial basement was constructed and was determined to be of Type V(111). The building is divided into 3 smoke compartments by 30 minute and 2-hour fire barriers.

The building is fully sprinkler protected in accordance with NFPA 13 The Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a manual fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification and installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition.

The facility has a capacity of 50 beds and had a census of 49 at the time of the survey.

Because the original building and the addition meet the construction type allowed for existing

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

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

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

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	245253	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/24/2014**

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K 000	Continued From page 1 buildings, the facility was surveyed as one building. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		