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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: P4UR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00579

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245470**

2.STATE VENDOR OR MEDICAID NO.
(L2) **842724100**

3. NAME AND ADDRESS OF FACILITY
(L3) **LIFECARE ROSEAU MANOR**
(L4) **715 DELMORE DRIVE**
(L5) **ROSEAU, MN** (L6) **56751**

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 **05/16/2012** (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 IMR	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 **60** (L18)

13.Total Certified Beds **60** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	60			
(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 :
Christy Johnson, Unit Supervisor 06/26/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege, Program Specialist 06/26/2012 (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
04/01/1987
(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
03/30/2012
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

Provider Number: 24-5470
Item 16 Continuation for CMS-1539

At the time of the standard survey completed on February 16, 2012, the facility was not in substantial compliance and the most serious deficiencies were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections are required. The facility was given an opportunity to correct before remedies were imposed.

Additionally, a Life Safety Code Federal Monitoring Survey (FMS) was completed at this facility on March 21, 2012. The facility was not in substantial compliance and the most serious deficiencies were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F). As a result of the FMS, CMS imposed following remedy:

- Mandatory DOPNA, effective May 16, 2012

In addition, CMS also informed the facility that if DOPNA went into effect, they would be subject to a loss of NATCEP for a two year period beginning May 16, 2012.

A Post Certification Revisit (PCR) was completed by the Minnesota Department of Health on April 2, 2012, by review of the plan of correction, and on May 16, 2012 the Minnesota Department of Public Safety completed a PCR for both the standard survey completed on February 16, 2012, and the FMS, completed on March 21, 2012.

As a result of the PCR's, it was determined that the facility had achieved substantial compliance pursuant to the standard survey completed on February 16, 2012, and the FMS completed March 21, 2012, effective April 27, 2012. As a result, the CMS RO concurred with the following imposition:

- Mandatory DOPNA, effective May 16, 2012, be rescinded

Since DOPNA would not go into effect, the facility would not be subject to NATCEP loss.

This facility's request for a temporary waiver involving K033 (issued at the time of the FMS survey) with a date of completion of June 8, 2012, has been approved

See attached CMS-2567B for the results of the April 2, 2012 and May 16, 2012 revisits.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5470

June 26, 2012

Mr. Keith Okeson, Administrator
Lifecare Roseau Manor
715 Delmore Drive
Roseau, Minnesota 56751

Dear Mr. Okeson:

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 April 27, 2012 the above facility is recommended for:

60 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 60 skilled nursing facility beds.

Your request for the temporary waiver of K033 has been approved based on the submitted documentation.

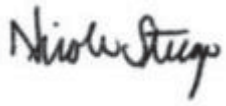
If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for this deficiency or renew your request for waiver in order to continue your participation in the Medicare Program.

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,



Nicole Steege, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4124 Fax #: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

June 26, 2012

Mr. Keith Okeson, Administrator
Lifecare Roseau Manor
715 Delmore Drive
Roseau, Minnesota 56751

RE: Project Number S5470038

Dear Mr. Okeson:

On March 1, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 16, 2012. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

In addition, on March 21, 2012, a surveyor representing the Region V Office of the Centers for Medicare and Medicaid Services (CMS) completed a Life Safety Code Federal Monitoring Survey (FMS) of your facility. As you were informed during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 2, 2012, CMS forwarded the results of the FMS to you and informed you that the following remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 16, 2012. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of April 2, 2012, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility may be prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 16, 2012.

On April 2, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction, and on May 16, 2012 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 16, 2012, and the FMS, completed on March 21, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 27, 2012. Based on our PCR's, we have determined that your

facility has corrected the deficiencies issued pursuant to the February 16, 2012 standard survey and the March 21, 2012 FMS, effective April 27, 2012. As a result of the findings of the PCR's, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in their letter dated April 2, 2012,. The CMS Region V Office concurs and has authorized this Department to notify you of the following actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 16, 2012, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective May 16, 2012, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment of all Medicaid admissions, effective May 16, 2012, is to be rescinded.

In the CMS letter of April 2, 2012, you were advised that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility would be prohibited from conducting NATCEP for two years from May 16, 2012, if denial of payment for new admissions should go into effect. Since your facility attained substantial compliance on April 27, 2012, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Correction of the Life Safety Code deficiency cited under K033 at the time of the March 21, 2012 FMS, has not yet been verified. Your plan of correction for this deficiency , including your request for a temporary waiver with a date of completion of June 8, 2012, has been approved. Failure to come into substantial compliance with this deficiency by the date indicated in your plan of correction may result in the imposition of enforcement remedies.

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 these visits.

Feel free to contact me if you have questions.

Sincerely,

Christy Johnson

Christy Johnson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 308-2114 Fax: (218) 308-2122

Enclosure

cc: Licensing and Certification File 5470R12FMS

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
245470	A. Building B. Wing	4/2/2012

Name of Facility	Street Address, City, State, Zip Code
LIFECARE ROSEAU MANOR	715 DELMORE DRIVE ROSEAU, MN 56751

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) -** LSC	Correction Completed **03/19/2012**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **03/19/2012**	ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **03/20/2012**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **03/23/2012**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **03/23/2012**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **03/20/2012**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **03/14/2012**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **03/20/2012**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **03/14/2012**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **03/20/2012**	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	CJ/NCS	6/26/12	12828	4/2/12
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
2/16/2012			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245470	CN - ROSEAU C & NC	5/16/2012

Name of Facility	Street Address, City, State, Zip Code
LIFECARE ROSEAU MANOR	715 DELMORE DRIVE ROSEAU, MN 56751

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0011	03/07/2012	ID Prefix Reg. # NFPA 101 LSC K0025	03/27/2012	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/NCS	Date: 6/26/12	Signature of Surveyor: 03006	Date: 5/16/12
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 2/14/2012

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245470	A. Building B. Wing **CN - ROSEAU C & NC**	5/16/2012

Name of Facility	Street Address, City, State, Zip Code
LIFECARE ROSEAU MANOR	715 DELMORE DRIVE ROSEAU, MN 56751

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	Correction Completed **03/28/2012**	ID Prefix	Correction Completed **04/04/2012**	ID Prefix	Correction Completed **04/10/2012**
Reg. # **NFPA 101** LSC K0021		Reg. # **NFPA 101** LSC K0022		Reg. # **NFPA 101** LSC K0025	
ID Prefix	Correction Completed **04/03/2012**	ID Prefix	Correction Completed **04/11/2012**	ID Prefix	Correction Completed **04/27/2012**
Reg. # **NFPA 101** LSC K0038		Reg. # **NFPA 101** LSC K0045		Reg. # **NFPA 101** LSC K0054	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By State Agency	**Reviewed By** PS/NCS	**Date:** 6/26/12	**Signature of Surveyor:** 03006	**Date:** 5/16/12
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 3/21/2012

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: P4UR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00579

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245470**
2.STATE VENDOR OR MEDICAID NO.
(L2) **842724100**

3. NAME AND ADDRESS OF FACILITY
(L3) **LIFECARE ROSEAU MANOR**
(L4) **715 DELMORE DRIVE**
(L5) **ROSEAU, MN** (L6) **56751**

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 **02/16/2012** (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 IMR	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 **60** (L18)

13.Total Certified Beds **60** (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	IMR
	60			
(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 :
Corrine Neisess, HFE-NEII 03/20/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege,Program Specialist 03/29/2012 (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
04/01/1987
(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
3/30/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

Provider Number: 24-5298
Item 16 Continuation for CMS-1539

At the time of the standard survey completed on February 16, 2012, the facility was not in substantial compliance and the most serious deficiencies were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3051 4068

March 1, 2012

Mr. Keith Okeson, Administrator
Lifecare Roseau Manor
715 Delmore Drive
Roseau, Minnesota 56751

RE: Project Number S5470038

Dear Mr. Okeson:

On February 16, 2012, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

<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:

Christy Johnson
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933

Telephone: (218) 308-2114

Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 27, 2012, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 27, 2012 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 16, 2012 (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 August 16, 2012 (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:

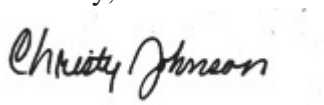
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Christy Johnson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 308-2114 Fax: (218) 308-2122

Enclosure

cc: Licensing and Certification File 5470S12.rtf

RECEIVED
MAR 16 2012
Minnesota Department of Health
Bemidji

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245470	A. BUILDING _____ B. WING _____	02/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFECARE ROSEAU MANOR	715 DELMORE DRIVE ROSEAU, MN 56751

(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 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 ONSITE 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=D	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	F 225	A standardized interview template has been added for use in all internal investigations. The template includes date, time, place and staff interview information. The vulnerable adult policy has been updated to direct staff to report immediately all reports of mistreatment, neglect, and abuse of resident and misappropriation of resident property to the appropriate officials in accordance with State and Federal laws. This plan will be monitored by the director of nursing reviewing all reports of mistreatment, neglect, abuse of residents andmisappropriation of resident property reports/ continued on page 2	3/19/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan C Russell — TITLE: Administrator — (X6) DATE: 3/15/12

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

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F 225	Continued From page 1 State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an allegation of potential mistreatment during a bath had been thoroughly investigated for 1 of 4 resident (R4) reviewed with an allegation of mistreatment. Findings include: The Abuse and Neglect policy revised 6/09, directed staff to conduct an internal investigation of any suspected maltreatment of a Vulnerable adult. The components of the investigation included: interviewing appropriate staff involved in the incident, deciding if a safety plan was needed, gathering appropriate information on the suspected perpetrator including a work history, and determining whether there had been past allegations of maltreatment.	F 225	Continued from page 1: allegations. This plan and monitoring will be reviewed at medical director/performance improvement meeting quarterly. Date of correction: 3-19-12	

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F 225	Continued From page 2 R4 was diagnosed with dementia with behavior disturbances and depression. The quarterly Minimum Data Set (MDS) dated 6/21/11, identified R4 as cognitively intact. The MDS also indicated R4 required total assistance from staff with all activities of daily living. The progress note dated 6/13/11, indicated R4 was very agitated and had accused the staff that had completed R4's bath as being rough and mean. R4 had also stated, "My hip hurts today because of it." The allegation was reported immediately and an internal investigation assessment and evaluation form was completed. The description of the investigation noted, "follow-up reveals staff followed protocol with bath, no mistreatment identified during bathing process" and that the staff working the evening shift of 6/12/11, had stated R4 "was very angry with bath, hitting, swearing, and etc." However, the internal form lacked documentation to determine if the allegation was substantiated, including who was interviewed, when the interviews took place, and what was stated by the staff interviewed. On 2/16/12, at 8:30 a.m. the director of nursing (DON) stated the perpetrators were interviewed separately and the stories matched, however, the investigation report lacked that information.	F 225	A standardized interview template has been added for use in all internal investigations. The template includes date, time, place and staff interview information. The vulnerable adult policy has been updated to direct staff to report immediately all reports of mistreatment, neglect, and abuse of residents and misappropriation of resident property to the appropriate officials in accordance with State and Federal laws. This plan will be monitored by the director of nursing reviewing all reports of mistreatment neglect, abuse of residents and misappropriation of resident property reports/ allegations. This plan and monitoring will be reviewed at medical director/performance improvement meeting quarterly. Date of correction: 3-19-12	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents	F 226		3/19/12

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F 226	Continued From page 3 and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow their established policy to ensure allegations of potential mistreatment had been thoroughly investigated for 1 of 4 resident (R4) reviewed with an allegation of mistreatment by staff during a bath. In addition, although the facility had reported allegations of potential mistreatment appropriately, a policy to ensure all reports of allegations would be reported immediately to the State agency was lacking. This practice had the potential to affect all 60 residents residing in the facility. Findings include: R4's report of potential mistreatment was not thoroughly investigated according to the facility's policy. The Abuse and Neglect policy revised 6/09, directed staff to conduct an internal investigation of any suspected maltreatment of a Vulnerable adult. The components of the investigation included: interviewing appropriate staff involved in the incident, deciding if a safety plan was needed, gathering appropriate information on the suspected perpetrator including a work history, and determining whether there had been past allegations of maltreatment. R4 was diagnosed with dementia with behavior disturbances and depression. The quarterly Minimum Data Set (MDS) dated 6/21/11,	F 226		

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F 226	Continued From page 4 identified R4 as cognitively intact. The MDS also indicated R4 required total assistance from staff with all activities of daily living. The progress note dated 6/13/11, indicated R4 was very agitated and had accused the staff that had completed R4's bath as being rough and mean. R4 had also stated, "My hip hurts today because of it." The allegation was reported immediately and an internal investigation assessment and evaluation form was completed. The description of the investigation noted, "follow-up reveals staff followed protocol with bath, no mistreatment identified during bathing process" and that the staff working the evening shift of 6/12/11, had stated R4 "was very angry with bath, hitting, swearing, and etc." However, the internal form lacked documentation to determine if the allegation was substantiated, including who was interviewed, when the interviews took place, and what was stated by the staff interviewed. On 2/16/12, at 8:30 a.m. the director of nursing (DON) stated the perpetrators were interviewed separately and the stories matched, however, the investigation report lacked that information. Abuse and Neglect Policy On 2/15/12, at 11:30 a.m. during a review of three of the facility's alleged violations (one dated 12/7/11, and two dated 1/26/12), it was determined the facility operationalized the correct	F 226	A standardized interview template has been added for use in all internal investigations. The template includes date, time, place and staff interview information. The vulnerable adult policy has been updated to direct staff to report immediately all reports of mistreatment, neglect, and abuse of resident and misappropriation of resident property tothe appropriate officials in accordance with State and Federal laws. This plan will be monitored by the director of nursing reviewing all reports of mistreatment, neglect, abuse of residents and misappropriation of resident property reports/ allegations. This plan and monitoring will be reviewed at medical director/performance improvement meeting quarterly. Date of correction 3-19-12	

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F 226	Continued From page 5 reporting system of allegations of potential mistreatment, abuse and neglect. However, the facility's policy did not reflect how staff operationalized reporting allegations of abuse or neglect. The Abuse and Neglect policy revised 6/09, directed staff to conduct an internal investigation of any suspected maltreatment of a Vulnerable adult. The reporting component of the policy indicated the internal team would decide, "whether the incident requires a report to the common entry point." On 2/16/12, at 11:40 a.m. social worker (SW)-A stated the facility was aware all allegations are to be reported to the State agency first and then investigated by the internal review team. SW-A verified the current policy was not correct and should be changed.	F 226		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication;	F 272	A tissue tolerance for resident 69 was completed on 2-16-12. Tissue tolerance indicated resident be repositioned every 1 hour and prn. An occupational therapy evaluation was completed on 2-23-12 with recommendation for stimulite cushion and hemi wheelchair. Cushion ordered and received/placed on wheel chair on 3-9-12. Another tissue tolerance with new cushion and wheelchair was completed on 3-9-12; Tissue tolerance indicated resident continued on page 7	3/20/12

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F 272	Continued From page 6 Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a comprehensive skin assessment that included a determination of the resident's individual repositioning needs for 1 of 2 residents (R69) in the sample with pressure ulcers. Findings include: R69 was diagnosed with a recent cerebrovascular accident (stroke) and chronic kidney disease. The admission Minimum Data	F 272	continued from page 6: to be repositioned every 2 hours and prn. Careplan updated to reflect these changed on 3-9-12. The facility policy titled skin protocol will be followed for all residents as outlined in deficiency F272. This policy will be reviewed on 3-20-12 at the LPN/RN meeting. Monitoring: This plan will be monitored by MDS nurses and Director of nursing. Random audits will be done to monitor compliance and reported to medical director /performance improvement meeting quarterly. Date of compliance: 3-20-12	

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F 272	Continued From page 7 Set (MDS) dated 12/12/11, indicated that R69 had no cognitive impairment and required extensive assistance with bed mobility and total assist for transfers. The MDS further indicated R69 had no pressure ulcers (PU) and was at risk for the development of PUs determined through a formal and clinical assessment. R69 was identified to utilize a pressure relieving device for her wheelchair and bed as well as a repositioning schedule. The Braden Scale (tool to predict pressure ulcer risk) dated 12/8/11, identified R69 as having a score of 13 with the form indicating a score of 12 or less represented high risk for pressure ulcer development. The "Checklist of Skin Risk Factors & Interventions" dated 12/8/11, identified the Braden Scale results and included interventions of turning and repositioning every 2 hours and the use of pressure reduction support surfaces in bed and with sitting. However, the record lacked documentation to determine the rationale for the 2 hour repositioning schedule. Review of the undated facility policy titled Skin Protocol indicated that a Tissue Tolerance Assessment would be initiated if the Braden scale was 14 or below and that both bed and sitting position assessments were to be done. Additionally, the policy identified that if the most recent MDS identified the resident needed limited assistance or greater with transferring, a sitting position Tissue Tolerance was to be done. If the resident was identified with limited assistance or greater with bed mobility, a bed Tissue Tolerance was to be done. The policy also identified the	F 272		

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F 272	Continued From page 8 Braden Scale would be done on admission, quarterly, and with a significant change in status. On 2/16/12, at 8:49 a.m. RN-A stated that R69 had been identified as at risk for pressure ulcers on admission to the facility. RN-A stated that interventions for prevention included a turning and repositioning schedule of every 2 hours and as needed. RN-A stated that the Tissue Tolerance Assessment is what staff would have used to determine the timing of the repositioning needs for R69. However, RN-A verified there was no Tissue Tolerance Assessment done on admission for either the lying or sitting positions until 2/14/12, and that included only a lying assessment. On 2/16/12, at 10:30 a.m. the director of nurses (DON) verified R69 should have had a lying and sitting Tissue Tolerance Assessment completed as part of the comprehensive assessment based on facility policy.	F 272		
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	F 282		3/23/12

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 282	Continued From page 9 by: Based on observation, interview, and document review, the facility failed to provide oral hygiene cares as directed by the plan of care (POC) for 1 of 1 resident (R38) in the sample who was dependent on staff for oral hygiene. Findings include: R38's diagnoses included organic brain syndrome. The annual Minimum Data Set (MDS) dated 11/15/11, identified R38 as requiring extensive assistance with personal hygiene. The current plan of care (POC) printed 2/15/12, identified R38 as having upper dentures and 6 bottom natural teeth. The plan of care directed the staff to remove dentures at bedtime and clean and soak them. In addition, staff were to encourage R38 to rinse and spit with mouth care twice daily. On 2/15/12, at 8:04 a.m. nursing assistant (NA)-A and NA-B provided morning cares for R38. At 8:25 a.m. NA-A stated R38's upper denture was placed after it had soaked all night. At 1:05 p.m. NA-B was told R38 had some natural teeth on the bottom. She stated she was not aware R38 had natural bottom teeth. NA-B stated R38 was given mouth wash in the a.m. She verified neither she nor NA-A had brushed R38's teeth. At 1:12 p.m. NA-B brought R38 to his room. R38's bottom teeth were observed to have plaque	F 282	In addition to residents plan of care dental care for residents that require assistance with oral hygiene will be added to the nursing assistants to-do list for documentation and compliance. Random observation audits of dental care will be done weekly by licensed staff. This plan will be monitored by charge nurse and the director of nursing and reported to the medical director/performance improvement meeting quarterly. Date of completion 3-23-12.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFECARE ROSEAU MANOR	715 DELMORE DRIVE ROSEAU, MN 56751

(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 282	Continued From page 10 build-up on them. NA-B verified R38 had not received tooth brushing this a.m. for his natural teeth. On 2/16/12, at 8:07 a.m. registered nurse (RN)-B stated the POC identified R38's mouth care twice daily. RN-B stated she would expect staff to brush the lower teeth according to the POC. At 10:55 a.m. the director of nursing verified the POC was not followed.	F 282		
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 adequate oral hygiene for 1 of 1 resident (R38) in the sample who had natural teeth and was dependent on staff for assistance with oral care. Findings include: R38's diagnoses included organic brain syndrome. The annual Minimum Data Set (MDS) dated 11/15/11, identified R38 as having moderate cognitive impairment, and as requiring extensive assistance with personal hygiene.	F 312	In addition to residents plan of care dental care for residents that require assistance with oral hygiene will be added to the nursing assistants to-do list for documentation and compliance. Random observation audits of dental care will be done weekly by licensed staff. This plan will be monitored by charge nurse and the director of nursing and reported to the medical director/performance improvement meeting quarterly. Date of completion: 3-23-12.	3/23/12

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F 312	Continued From page 11 The current plan of care (POC) printed 2/15/12, identified R38 as having upper dentures and 6 bottom natural teeth. The plan of care directed the staff to remove dentures at bedtime and clean and soak them. In addition, staff were to encourage R38 to rinse and spit with mouth care twice daily. On 2/15/12, at 8:04 a.m. nursing assistant (NA)-A and NA-B provided morning cares for R38. At 8:25 a.m. NA-A stated R38's upper denture was placed after it had soaked all night. At 1:05 p.m. NA-B was told R38 had some natural teeth on the bottom. She stated she was not aware R38 had natural bottom teeth. NA-B stated R38 was given mouth wash in the a.m. She verified neither she nor NA-A had brushed R38's teeth. At 1:12 p.m. NA-B brought R38 to his room, and found that the resident had 6 teeth on the bottom. NA-B stated she had not known R38 had teeth on the bottom. NA-B stated staff probably assume since R38 has an upper denture, he has no teeth on the bottom. At that time, R38's bottom teeth were observed to have plaque build-up on them. NA-B verified R38 had not received tooth brushing this a.m. for his natural teeth. NA-B stated the report sheet she carried in her pocket did not address the natural teeth or oral hygiene. At that time, in the bathroom medicine cabinet, a denture cleaning brush, toothpaste, and Efferdent were noted. However, there was no toothbrush in the bathroom.	F 312		

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F 312	Continued From page 12 At 1:58 p.m. NA-C stated she did not know R38 had bottom teeth. She stated she had done R38's oral cares many time and knew he had a top denture. NA-C stated NA-B had just told her about R38's teeth and NA-B had just brushed them. NA-B had stated the teeth had a bunch of "gunk" in them and R38 needed oral hygiene. At 2:05 p.m. NA-C stated they have a "to do list" they print off each shift. She verified it did not address R38's oral hygiene or lower teeth. On 2/16/12, at 8:07 a.m. registered nurse (RN)-B stated the POC identified R38's mouth care twice daily. RN-B stated she would expect staff to brush the lower teeth according to the POC. At 10:55 a.m. the director of nursing verified the POC was not followed.	F 312		
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 review, the facility failed to accurately monitor skin integrity and ensure the resident received an	F 314	A tissue tolerance for resident 69was completed on 2-16-12. Tissue tolerance indicated resident be repositioned every 1 hour and prn. An occupational therapy evaluation was completed on 2-23-12 with recommendation for stimulite cushion and hemi wheelchair. Cushion ordered and received/placed on wheelchair on 3-9-12. Another tissue tolerance with new cushion and wheelchair was completed on 3-9-12. Tissue tolerance indicated resident to be repositioned every 2 hours and prn. Continued on page 14	3/20/12

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F 314	Continued From page 13 appropriate individualized repositioning schedule to minimize the risk of pressure ulcer development for 1 of 2 residents (R69) in the sample with a pressure ulcer. Findings include: R69 was diagnosed with a recent cerebrovascular accident (stroke) and chronic kidney disease. The admission Minimum Data Set (MDS) dated 12/12/11, indicated that R69 had no cognitive impairment and required extensive assistance with bed mobility and total assist for transfers. The MDS further indicated R69 had no pressure ulcers (PU) but was at risk for the development of PUs determined through a formal and clinical assessment. R69 was identified to utilize a pressure relieving device for her wheelchair and bed as well as a repositioning schedule. The Pressure Ulcer Care Area Assessment (CAA) dated 12/21/11, indicated R69 was at risk for PUs due to risk factors including immobility, incontinence, recent decline in activities of daily living, and functional limitations in range of motion. Further risk factors included the diagnoses of cerebrovasular accident with hemiplegia (weakness of one side), depression, chronic or end-stage renal disease and pain. The Braden Scale (tool to predict pressure ulcer risk) dated 12/8/11, and 12/21/11, identified R69 as at risk for pressure ulcer development with a score of 13. The form indicated a score of 12 or less represented high risk for pressure ulcer development.	F 314	Continued from page 13: Careplan updated to reflect these changes on 3-9-12. The facility policy titled skin protocol will be followed for all residents as outlined in deficiency F272. This policy will be reviewed on 3-20-12 at the LPN/RN meeting. Monitoring: This plan will be monitored by MDS nurses and director of nursing. Random audits will be done to monitor compliance and reported to medical director /performance improvement meeting quarterly. Date of compliance: 3-20-12	

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F 314	Continued From page 14 The Checklist of Skin Risk Factors & Interventions dated 12/8/11, and 12/21/11, identified the Braden Scale results and included interventions of turning and repositioning every 2 hours and the use of pressure reduction support surfaces in bed and with sitting. However, the record lacked documentation to support the rationale for the 2 hour repositioning schedule. Review of the undated policy Skin Protocol, indicated that a Tissue Tolerance Assessment would be initiated if the Braden scale was 14 or below and that both bed and sitting position assessments were to be done. Additionally, the policy identified that if the most recent MDS identified the resident needed limited assistance or greater with transferring, a sitting position Tissue Tolerance was to be done. If the resident was identified with limited assistance or greater with bed mobility, a bed Tissue Tolerance was to be done. The policy also identified the Braden Scale would be done on admission, quarterly, and with a significant change in status. The plan of care (POC) dated 1/19/12, indicated R69 was dependent on staff for turning and directed staff to reposition R69 every 2 hours and as needed, and provide a wheelchair cushion and a pressure relief mattress. The POC, revised at the time of the survey on 2/16/12, directed staff to provide R69 with an alternating pressure pad system to the bed. Review of the nursing progress notes indicated: On 12/8/11, the initial skin assessment indicated R69 had no areas of redness or skin breakdown.	F 314		

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F 314	Continued From page 15 On 1/1/12, R69 had a 2 cm open "abrasion" on the left buttock cheek. The area was cleansed and Lyofoam and Duoderm (wound care products) were implemented. On 1/3/12, R69 had an open area on the left buttock with Cavilon and Duoderm (wound care products) re-applied. On 1/5/12, R69's open area was "about 2 cm." On 1/10/12, R69 continued to have a skin "abrasion" on the left buttock and R69 was repositioned every two hours. Further nursing notes indicated incomplete and sometimes conflicting documentation regarding R69's skin integrity with no indication when the "abrasion" was determined as resolved: On 1/16/12, no "abrasion" or dressing could be found on R69 and the skin was left open to air. On 1/17/12, R69 had Duoderm on an "abrasion" on her coccyx with a pressure relief mattress on the bed and pressure relief cushion in the wheelchair. On 1/25/12, at 12:11 p.m. R69 was seen for skin rounds by the registered nurse (RN) and the physical therapy aide (PTA) with no problems noted on right or left buttocks. On 1/25/12, at 12:15 p.m. a pressure reducing air mattress was initiated after discussion at the facility's skin rounds identified R69 was at risk and would benefit from additional pressure prevention interventions.	F 314		

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F 314	Continued From page 16 The nursing progress note dated 2/9/12, indicated R69 had developed a wound to the right of her coccyx. No further comprehensive skin assessment, including an assessment of R69's individual repositioning schedule, was noted in the clinical record at that time. Further nursing notes indicated: On 2/9/12, R69's wound on the right of her coccyx was .5 cm open. The area was cleansed and dried, with Cavilon spray, Polymen and Duoderm (wound care products) applied. On 2/13/12, at 4:50 p.m. R69 had a discolored area 2.6 cm X 3.2 cm, with a superficial open area 1.8 cm X 1.6 cm with tissue covering the center 0.3 cm. On 2/13/12, at 11:45 p.m. R69 was identified with a pressure ulcer that was unstageable (known but not stageable due to the coverage of the wound by nonviable tissue) on her coccyx. Assessment by 2 RNs noted a measurement of 1.7 cm X 1.2 cm with a dark center and white perimeter with blanchable redness surrounding that was not measured. The area was noted as not open at present, and staff anticipated it would open with a plan to refer it to the facility's skin rounds. The facility's Tissue Tolerance Assessment form dated 2/14/12, indicated R69 was noted to have pink blanchable areas noted to buttocks and sacrum 2 hours after positioned lying that would	F 314		

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F 314	Continued From page 17	F 314		

clear when off loaded (repositioned) 1/2 hour. R69 was noted to have pink blanchable area noted to buttocks and sacrum at 2 1/2 hours after lying with pink blanchable area to hip. No Tissue Tolerance Assessment for seating and no admission assessment of lying could be found in the record.

On 2/15/12, at 8:11 a.m. licensed practical nurse (LPN)-A was observed to assess R69's coccyx area. LPN-A stated the Duoderm which was observed to be loose needed to be changed. LPN-A completed the dressing change at 8:15 a.m. with the open area observed, but not measured. The tissue surrounding the open area appeared to have a dull/darker hue with minimal redness.

On 2/15/12, at 8:27 a.m. R69 was transferred to the wheelchair via a mechanical lift to be taken out to the dining room for breakfast.

On 2/15/12, at 9:38 a.m. R69 was taken back to her room and transferred to bed to be seen for skin rounds by RN-A and PTA-A. PTA-A stated this was the first time the skin team was seeing R69 for this open area, but the resident had been seen a couple of weeks prior when there was a report that R69 had an area of redness on her coccyx. PTA-A stated at that time, there was no redness or open areas.

At 9:44 a.m. PTA-A removed the Duoderm and measured the wound as 1.3 cm by 0.8 cm open. Redness was noted extending laterally from both edges of the open wound. RN-A and PTA-A decided to change the current treatment to Xerofoam (wound care product) covered by

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F 314	Continued From page 18 Duoderm. RN-A stated that clearly the Duoderm was not enough and that she would consider the area an unstagable pressure ulcer because of the slough on the wound and location. On 2/15/12, at 1:11 p.m. LPN-A stated she was not sure when the current PU started, but thought it was open on 2/11/12. On 2/16/12, at 8:49 a.m. RN-A stated that R69 had been identified as at risk for pressure ulcers on admission to the facility. RN-A stated that the initial "abrasion" reported on the buttocks had been reviewed with the director of nurses (DON). They had determined this was a result of R69 pulling herself towards the grab bars and creating shear, so the grab bars had been removed. RN-A stated this area was not considered a PU. RN-A stated the current PU was first reported on 2/9/12, with Polymen and Duoderm treatment started. RN-A added on 2/13/12, it was determined to be an unstagable PU. RN-A verified that there were two different set of measurements for 2/13/12, and stated this was because two different staff had done the measurements. RN-A stated that interventions for the prevention of PUs for R69 included a turning and repositioning schedule of every 2 hours and as needed. RN-A stated that the Tissue Tolerance Assessment is what staff would have used to determine the timing of the repositioning needs for R69. However, RN-A verified there was no Tissue Tolerance Assessment done on admission for either the lying or sitting positions, and the assessment done 2/14/12, included only a lying assessment. On 2/16/12, at 10:30 a.m. the director of nurses	F 314		

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F 314	Continued From page 19 verified R69 should have had a lying and sitting Tissue Tolerance Assessment completed as part of the comprehensive assessment based on facility policy.	F 314		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	Consulting pharmacist comments/recommendations on 2-23-12 state; resident on Remeron 7.5mg at HS for insomnia and Celexa 10mg daily for anxiety/depression. Per CMS regulations consider trial hold of Remeron or document continued rationale for use. Resident has failed Remeron discontinuation in 2009. Meds for insomnia require every 3 months documentation or update if Remeron is for insomnia, as well as depression/anxiety. On 2-29-12 doctor reviewed consulting pharmacist comments/recommendations with orders to change Remeron 7.5mg po at HS to as needed for insomnia/restlessness. Sleep monitoring was continued on page 21	3/14/12

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F 329	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to adequately monitor sleep patterns to determine the effectiveness and continued use of an antidepressant medication used for insomnia for 1 of 10 residents (R31) in the sample reviewed for medication use. Findings include: R31 was diagnosed with dementia, insomnia, depression, and anxiety. The quarterly Minimum Data Set (MDS) dated 1/17/12, identified R31's cognitive impairments and as having trouble falling or staying asleep several days. The MDS indicated R31 required total assistance from staff with all activities of daily living. The current physician's orders indicated Remeron 7.5 mg was initiated on 8/31/10, for insomnia. However, the medical record lacked a sleep log or documentation to indicate R31's insomnia or sleep patterns were monitored except for the month of December 2011. At that time, two entries were documented on the behavior monitoring record. Further review of the physician's orders indicated R31 had received an order to initiate another antidepressant (Celexa 20 mg. every day) on 3/3/11, for increasing agitation, restless, increase in repetitive questions and not sleeping well at night. This medication was decreased on 9/14/11, to Celexa 10 mg. every day with no problems noted.	F 329	continued from page 20; completed per facility policy with change of medication frequency. On 3-14-12 doctor was notified of increased anxiety and restlessness with orders to restart Remeron 7.5mg po daily at HS. Monitoring of insomnia will continue at this time. Facility policy on sleep monitoring will be followed on on all residents. This plan wil will be monitored by psychotropic drug nurse and director of nursing doing random audits on medication to ensure compliance with State and Federal regulations and that residents receive appropriate monitoring of medications. Consulting licensed pharmacist will continue to review and report any irregularities to the attending physician, and the director of nursing monthly. This plan and monitoring will be reviewed at medical director/performance improvement meeting quarterly. Date of Correction: 3-14-12	

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F 329	Continued From page 21 On 2/16/12, at 9:50 a.m. registered nurse (RN)-B verified R31 received Remeron for insomnia and the only documentation related to R31's sleep patterns was on the December 2011 behavior monitoring record. The facility's psychotropic medication monitoring policy dated 4/10 indicated a sleep log would be completed quarterly in coordination with the MDS.	F 329		
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.	F 356		3/20/12

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F 356	Continued From page 22 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 by: Based on observation, interview, and document review, the facility failed to include the resident census on the required daily nurse staffing posting. This practice had the potential to affect all 60 residents residing in the facility and visitors. Findings include: On 2/13/12, at 1:58 p.m. the daily nurse staffing posting was observed to include a section identified as the resident census. However, the resident census was not identified. On 2/14/12, at 3:29 p.m. the daily nurse staffing posting did not address the resident census. On 2/15/12, at 8:00 a.m. the daily nurse staffing posting did not address the resident census. On 2/16/12, at 11:00 a.m. the director of nursing (DON) verified the resident census was blank on the daily nurse staffing posting everyday from 2/13/12, through 2/16/12. The DON stated the night staff were responsible for filling in the resident census on the staff posting. The Staffing Requirement policy and procedure revised 6/09, identified full time equivalents of licensed nursing staff for each day would be posted. The policy did not address identifying the resident census on the daily nurse staffing	F 356	Education was provided to licensed staff regarding proper completion of required daily nursing staffing posting and resident census on 2-16-12. Facility policy on staffing was updated on 3-14-12 to incorporate posting of facility name, current date, total number and actual hours worked by licensed and unlicensed staff directly responsible for resident care per shift and resident census. A LPN/RN meeting will be held on 3-20-12 to review new policy and requirements. This plan will be monitored by licensed night staff and director of nursing. Compliance will be reported to medical director/performance improvement quarterly. Date of completion: ~~2-16-12~~ 3/20/12	

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	245470	A. BUILDING _____ B. WING _____	02/16/2012

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F 356	Continued From page 23 posting.	F 356		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an irregularity, related to an antidepressant medication used for insomnia without adequate monitoring of it's effectiveness, was reported by the pharmacist to the resident's physician and the director of nursing for 1 of 10 residents (R31) in the sample reviewed for unnecessary medications. Findings include: R31 was diagnosed with dementia, insomnia, depression, and anxiety. The quarterly Minimum Data Set (MDS) dated 1/17/12, identified R31's cognitive impairments and as having trouble falling or staying asleep several days. The current physician's orders indicated Remeron 7.5 mg was initiated on 8/31/10, for insomnia. However, the medical record lacked a sleep log	F 428	Consulting pharmacist comment/recommendations on 2-23-12 state; resident on Remeron 7.5mg at HS for insomnia and Celexa 10mg daily for anxiety/depression. Per CMS regulations consider trial hold of Remeron or document continued rationale for use. Resident has failed Remeron discontinuation in 2009. Meds for insomnia require evey 3 month documentation or update if Remeron is for insomnia, as well as depression/anxiety. On 2-29-12 doctor reviewed consulting pharmacist comments/recommendations with orders to change Remeron 7.5mg po at HS to as needed for insomnia/restlessness. Sleep monitoring was completed per facility policy with change of medication frequency. On 3-14-12 doctor was notified of increased anxiety and restlessness with orders to restart Remeron 7.5mg po daily at HS. Monitoring of insomnia will continue at this time. Facility policy on sleep monitoring will be follow continued on page 25	3/14/12

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F 428	Continued From page 24 or documentation to indicate R31's insomnia or sleep patterns had been monitored except for the month of December 2011. At that time, two entries were documented on the behavior monitoring record. Further review of the physician's orders indicated R31 had received an order to initiate another antidepressant (Celexa 20 mg. every day) on 3/3/11, for increasing agitation, restless, increase in repetitive questions and not sleeping well at night. This medication was decreased on 9/14/11, to Celexa 10 mg. every day with no problems noted. The pharmacist's monthly drug regimen review dated 1/19/12, failed to identify and report R31's sleep patterns had not been monitored. The pharmacist noted R31 had been hitting, swearing and trying to hit. The pharmacist indicated he/she would be reluctant to ask for "psych. meds reduction." On 2/16/12, at 9:50 a.m. the pharmacist's reviews were reviewed with registered nurse (RN)-B. RN-B verified R31 received Remeron for insomnia and the record lacked documentation R31's sleep pattern had been monitored except in December 2011.	F 428	continued from page 24; on all residents. This plan will be monitored by psychotropic drug nurse and director of nursing doing random audits on medications to ensure compliance with State and Federal regulations and that residents receive appropriate monitoring of medications. Consulting licensed pharmacist will continue to review and report any irregularities to the attending physician and the director of nursing monthly. This plan and monitoring will be reviewed at medical director/performance improvement meeting quarterly. Date of correction: 3-14-12	
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.	F 441		3/20/12

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F 441	Continued From page 25 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate infection control measures, related to proper hand hygiene and technique, were followed during wound cares for 2 of 2 residents (R8,	F 441	On 3-1-12 the Director of Rehab Services completed education/training on wound care/infection control with all physical therapy staff that provide dressing changes. The Director of Nursing has provided individual education to nursing staff regarding facility dressing change policy and wound care/infection control measures. A LPN/RN meeting will be held on 3-20-12 to further address wound care and infection control practices. Long term mandatory annual inservices being held March-May 2012 will also provide reeducation/reinforcement of wound care and infection control practices. Random observation by director of nursing will be done on dressing changes/infection control practices weekly x1 month. If further concerns noted will continue random observation audits quarterly. The plan will be monitored by director of nursing and reported to medical director/ continued on page 27	

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F 441	Continued From page 26 R69) observed during a dressing change for which infection control practices to prevent cross contamination would have been indicated. Findings include: R69 was diagnosed with a recent cerebrovascular accident (stroke) and chronic kidney disease. The admission Minimum Data Set (MDS) dated 12/12/11, indicated that R69 had no cognitive impairment. The nursing progress note on 2/9/12, indicated R69 had developed a wound to the right of her coccyx that was open 0.5 cm. Additionally on 2/13/12, the nursing progress notes identified this area as an unstageable pressure ulcer PU (known but not stageable due to the coverage of the wound by nonviable tissue) that was being treated with a duoderm dressing that was changed every three days and as needed. On 2/15/12, at 8:15 a.m. licensed practical nurse (LPN)-A was observed to complete a change of the Duoderm dressing for R69. LPN-A set the tray containing dressing supplies on R69's bedside table. LPN-A then donned nonsterile gloves and removed the loose Duoderm from R69's pressure ulcer and disposed of it into the garbage. At 8:16 a.m. LPN-A reached into the dressing tray without removing the soiled gloves and took out a packaged gauze dressing which she opened. LPN-A removed a bottle of saline from the tray which she opened and poured the saline onto the gauze dressing. LPN-A set the saline on the bedside stand and then used the wet gauze	F 441	continued from page 26; performance improvement meeting quarterly. Date of correction: 3-20-12	

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F 441	Continued From page 27 dressing to cleanse the pressure ulcer area. LPN-A then disposed of the gauze dressing into the garbage. LPN-A then reached into the tray with the same gloves and took out a Duoderm dressing and a pair of scissors which she used to cut a piece of Duoderm dressing. LPN-A put the unused Duoderm back into the tray and set the scissors on the bedside stand. At 8:17 a.m. LPN-A put the scissors back into the tray and placed the Duoderm dressing over R69's pressure ulcer. At 8:18 a.m. LPN-A replaced the cover on the saline bottle and placed it into the dressing tray. LPN-A then removed her gloves and stood at the bedside to talk with the staff that were working with R69. LPN-A touched her face/nose and hair with her hands. At 8:23 a.m. LPN-A picked up the dressing tray and walked towards the door. LPN-A then placed the dressing tray down on the foot of R69's roommate's bed and went into the bathroom and washed her hands. At 8:24 a.m. LPN-A walked out of the room with the dressing tray. LPN-A stated that the dressing tray was used for other residents' dressing changes. On 2/15/12, at 1:11 p.m. LPN-A stated she should have removed her gloves after she took the old dressing off, and then wash her hands and put on new gloves. LPN-A stated she should not have reached into the tray for supplies with the soiled gloves after she had handled the old dressing. LPN-A stated that she had placed the	F 441		

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F 441	Continued From page 28 dressing tray down on R69's roommate's bed because she did not know where a more appropriate place to put it would have been. LPN-A verified she had made several breaks in infection control techniques with the dressing change. On 2/16/12, at 8:49 a.m. RN-A verified staff had been trained to change their gloves between handling an old dressing and a new dressing and to complete hand hygiene in between. RN-A verified that staff had been instructed to not reach into the dressing supply tray with gloves that had been used during a dressing change. On 2/16/12, at 10:12 a.m. the director of nurses (DON) was informed of the observations with the dressing change done by LPN-A on 2/15/12. She verified that LPN-A had not followed correct handwashing and infection control practices with the dressing change. The undated facility policy titled Dressing Changes directed staff to remove gloves after removing the old dressing and to wash hands. Additionally, staff were then to put on clean gloves to apply the new dressing, then remove gloves and wash hands. R8 was diagnosed with dementia. The quarterly MDS dated 1/24/12, indicated had 2 unstageable pressure ulcers (PUs) (not stageable due to coverage of the wound bed by slough and/or eschar). On 2/1/12, the Physician Orders indicated R8	F 441		

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F 441	Continued From page 29 would be started on antibiotic therapy for an infection to the right hip wound. On 2/15/12, at 10: 53 a.m. physical therapist (PT) -A was observed to provide wound care to R8. PT-A was observed to don 2 pair of gloves. At this time, PT-A stated she double gloved to save the need for handwashing in between removing the dirty dressing and applying the clean dressing. PT-A was then observed to remove the soiled dressing from R8's right hip wound. PT-A disposed of the soiled dressing and reached inside a container with dressing supplies and touched items in the container for the new dressing. PT-A then removed her outer pair of gloves, which left one pair of gloves still on. PT-A was then observed to don a clean pair of gloves over the top of the gloves still on her hands. PT-A was observed to use a single use tool to debride (removal of dead tissue) R8's wound. PT-A then wiped off the debriding tool with a 2 x 2 bandage, and then placed the tool in the original container. PT-A applied the new dressing and then removed both gloves and cleansed her hands with an alcohol based cleanser. At 11:09 a.m. PT-A donned a clean pair of gloves and removed the soiled dressing from R8's coccyx wound. PT-A used the same debriding tool on the coccyx as she had used on the right hip. PT-A again wiped off the debriding tool with a 2 x 2 bandage and then placed the tool in the original container.	F 441		

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F 441	Continued From page 30 PT-A was observed to touch the inside of the dressing supply container with her soiled gloves and touch various items in the box. PT-A cleansed the wound and then removed the soiled gloves. PT-A was observed to cleanse her hands with alcohol, apply new gloves, and then apply the new dressing. At 11:18 a.m. PT-A was observed to cleanse her hands with alcohol, apply new clean gloves and remove a dressing to R8's left gluteal crease. Without changing gloves, she removed the dressing from R8's left hip. PT-A stated at this time, she believed R8's right hip had been infected and the resident was on an antibiotic for the infection. At 11:21 a.m. PT-A used the same tool to debride the left hip. PT-A wiped off the debriding tool with a 2 x 2 bandage, then placed the tool in the original container. PT-A removed her gloves and cleansed her hands with alcohol and placed new gloves. PT-A obtained the dressing supplies out of the same container in which she had touched the supplies with her soiled gloves to obtain the new dressings. PT-A applied the new dressing to the left gluteal fold and the left hip. PT-A then removed her soiled gloves and cleansed her hands with alcohol. At 11:29 a.m. PT-A applied new gloves and removed the dressing on the left side of R8's back. PT-A used the same tool, used on the previous wounds, to debride the wound. She then wiped it off with a 2 x 2 and placed in the same container. PT-A then removed her gloves,	F 441		

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F 441	Continued From page 31	F 441		

cleansed her hands, and applied new gloves. PT-A obtained the dressing and applied the clean dressing. Next, PT-A removed the soiled dressing to the wound on the left scapula without changing her gloves. PT-A stated she noted a strong smell from the wound. The wound was observed to be red and inflamed with drainage. Initially, the PT stated she thought the wound needed to be cultured. PT-A reached in the supply container with her soiled gloves to obtained items to cleanse the wound. The PT used the same debriding tool as she had used on all the other wounds to debride the wound. PT-A removed her gloves, cleansed her hands, and placed new gloves. The PT stated the wound did not smell as strong as it did after she cleansed it. The PT applied the new dressing to the wound. PT-A removed her gloves and cleansed her hands when she was completed with wound care.

At 11:53 a.m. PT-A stated she double gloves to save on one hand wash between removing the dirty dressing and applying the new dressing. She stated they have been told they could do that, and the practice is part of the hospital wide policy. PT-A stated she uses the debriding tool on all wounds and felt this was okay because it was used on the same resident. She stated she was not concerned about cross contamination because the organism was internalized so the same organisms would be in every wound. PT-A added R8 is on an antibiotic so that would cover any infection.

On 2/16/12, at 11:34 a.m. the director of nursing (DON) stated double gloving does not follow the policy. The DON added she did not think using the same tool on each wound would be following

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F 441	Continued From page 32 the policy either. The DON agreed that it is not good infection control practice to touch the inside of the wound supply box with dirty gloves. The undated facility policy titled Dressing Changes directed staff to remove gloves after removing the old dressing and to wash hands. Additionally, staff were then to put on clean gloves to apply the new dressing, then remove gloves and wash hands.	F 441		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Lifecare Roseau Manor 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: PATRICK SHEEHAN SUPERVISOR STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST PAUL, MN 55101-5145 Email: pat.sheehan@state.mn.us	K 000	RECEIVED MAR 19 2012 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION POC ok PS 3-20-12	

DC: 03.28.2012

EXIT: 02.16.2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Susan C Tisell	Administrator	3-15-12

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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K 000	Continued From page 1 Fax Number 651-215-0525 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Lifecare Roseau Manor was built at two different times. The first building was an addition to the hospital and was built in 1972. It is 1-story with a basement and was determined to be Type II(111) construction with a 2- hour fire barrier between the hospital and the care manor. In 1993 an addition was built to the north of the original structure, is 1-story with a basement and determined to be Type II (000) construction. The facility is divided into 7 smoke zones, two on the basement level, by 30 minute and 2-hour fire barriers. The facility is completely sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). The facility has a fire alarm system which includes corridor smoke detection throughout and in all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. All sleeping rooms have smoke detectors and all hazardous areas have automatic fire detectors in accordance with the Minnesota State	K 000		

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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
K 000	Continued From page 2 Fire Code 2007 edition. The fire alarm system is monitored for automatic fire department notification. The facility has a capacity of 64 beds and had a census of 60 at the time of the survey. The facility was surveyed as one building. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Observations revealed that one of two fire rated barriers is not in accordance with NFPA 101 "The Life Safety Code" (2000 edition) section 19.1.1.4.1. This deficient practice could negatively affect all of the residents, staff and visitors in the event of a fire by allowing fire and smoke to pass from one building to the other. Findings include: During the facility tour on February 14, 2012, between 10:00 am and 12:30 pm, observations revealed that the 2-hour fire barrier between the hospital and the manor buildings has	K 011	Sealed with mortar top of wall. Date of correction: 2-23-12 and 2-24-12 Sealed duct penetration with fire caulk. Date of correction: 3-7-12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245470	A. BUILDING CN - ROSEAU C & NC B. WING _____	02/14/2012

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K 011	Continued From page 3 approximately 3 feet of wall that is not complete to the roof deck found near the volunteer's office and an unsealed duct penetration above the ceiling in the volunteer's office was also found. The Director of Maintenance (BG) verified these findings during the inspection and with the CEO (KO) at the exit conference.	K 011		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Observations revealed that two of four smoke barriers were not in accordance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 8.3.6. This deficient practice could allow the products of combustion to travel throughout the building by passing through the smoke barrier, which will negatively impact all of the residents, staff and visitors. Findings include: During the facility tour on February 14, 2012, between 10:00 am and 12:30 pm, observations	K 025	Sealed pipes with fire caulk. (Room 158) Date of compliance: 2-27-12 Sealed pipes with firestop puddy. (Cherry Wood Lane) Date of compliance: 2-24-12	

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K 025	Continued From page 4 revealed that : 1) The Pine Wood Lane smoke barrier has an unsealed conduit penetrating the wall in room 158, above the ceiling, and 2) The Cherry Wood Lane smoke barrier has a new wiring sleeve through it, above the corridor ceiling, that has not been sealed properly. The Director of Maintenance (BG) verified these findings during the inspection and with the CEO (KO) at the exit conference.	K 025		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3051 4068

March 1, 2012

Mr. Keith Okeson, Administrator
Lifecare Roseau Manor
715 Delmore Drive
Roseau, Minnesota 56751

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5470038

Dear Mr. Okeson:

The above facility was surveyed on February 13, 2012 through February 16, 2012 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

and the Time Period For Correction.

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

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

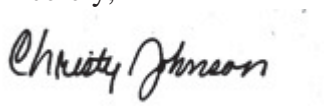
When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 705 5th Street NW, Suite A, Bemidji, Minnesota 56601-2933. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,



Christy Johnson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 308-2114 Fax: (218) 308-2122

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00579	A. BUILDING _____ B. WING _____	02/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFECARE ROSEAU MANOR	715 DELMORE DRIVE ROSEAU, MN 56751

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On February 13, 14, 15, & 16 2012, surveyors of this Department's staff, visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

Jason C. Riell — TITLE: Administrator — (X6) DATE: 3/15/12
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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2 000	Continued From page 1 Certification Program; 705 5th St. N.W., Suite A, Bemidji, MN 56601-2933	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision	2 540		

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2 540	Continued From page 2 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete a comprehensive skin assessment that included a determination of the resident's individual repositioning needs for 1 of 2 residents (R69) in the sample with pressure ulcers. Findings include: R69 was diagnosed with a recent cerebrovascular accident (stroke) and chronic kidney disease. The admission Minimum Data Set (MDS) dated 12/12/11, indicated that R69	2 540		

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2 540	Continued From page 3 had no cognitive impairment and required extensive assistance with bed mobility and total assist for transfers. The MDS further indicated R69 had no pressure ulcers (PU) and was at risk for the development of PUs determined through a formal and clinical assessment. R69 was identified to utilize a pressure relieving device for her wheelchair and bed as well as a repositioning schedule. The Braden Scale (tool to predict pressure ulcer risk) dated 12/8/11, identified R69 as having a score of 13 with the form indicating a score of 12 or less represented high risk for pressure ulcer development. The "Checklist of Skin Risk Factors & Interventions" dated 12/8/11, identified the Braden Scale results and included interventions of turning and repositioning every 2 hours and the use of pressure reduction support surfaces in bed and with sitting. However, the record lacked documentation to determine the rationale for the 2 hour repositioning schedule. Review of the undated facility policy titled Skin Protocol indicated that a Tissue Tolerance Assessment would be initiated if the Braden scale was 14 or below and that both bed and sitting position assessments were to be done. Additionally, the policy identified that if the most recent MDS identified the resident needed limited assistance or greater with transferring, a sitting position Tissue Tolerance was to be done. If the resident was identified with limited assistance or greater with bed mobility, a bed Tissue Tolerance was to be done. The policy also identified the Braden Scale would be done on admission, quarterly, and with a significant change in status.	2 540		

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2 540	Continued From page 4 On 2/16/12, at 8:49 a.m. RN-A stated that R69 had been identified as at risk for pressure ulcers on admission to the facility. RN-A stated that interventions for prevention included a turning and repositioning schedule of every 2 hours and as needed. RN-A stated that the Tissue Tolerance Assessment is what staff would have used to determine the timing of the repositioning needs for R69. However, RN-A verified there was no Tissue Tolerance Assessment done on admission for either the lying or sitting positions until 2/14/12, and that included only a lying assessment. On 2/16/12, at 10:30 a.m. the director of nurses (DON) verified R69 should have had a lying and sitting Tissue Tolerance Assessment completed as part of the comprehensive assessment based on facility policy. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review and revise policies and procedures pertaining to resident assessments to assure they comply with the regulations, retrain staff, and develop a monitoring procedure. TIME PERIOD FOR CORRECTION: Twenty one (21) Days	2 540		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.	2 565		

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2 565	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide oral hygiene cares as directed by the plan of care (POC) for 1 of 1 resident (R38) in the sample who was dependent on staff for oral hygiene. Findings include: R38's diagnoses included organic brain syndrome. The annual Minimum Data Set (MDS) dated 11/15/11, identified R38 as requiring extensive assistance with personal hygiene. The current plan of care (POC) printed 2/15/12, identified R38 as having upper dentures and 6 bottom natural teeth. The plan of care directed the staff to remove dentures at bedtime and clean and soak them. In addition, staff were to encourage R38 to rinse and spit with mouth care twice daily. On 2/15/12, at 8:04 a.m. nursing assistant (NA)-A and NA-B provided morning cares for R38. At 8:25 a.m. NA-A stated R38's upper denture was placed after it had soaked all night. At 1:05 p.m. NA-B was told R38 had some natural teeth on the bottom. She stated she was not aware R38 had natural bottom teeth. NA-B stated R38 was given mouth wash in the a.m. She verified neither she nor NA-A had brushed R38's teeth. At 1:12 p.m. NA-B brought R38 to his room. R38's bottom teeth were observed to have plaque	2 565		

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2 565	Continued From page 6 build-up on them. NA-B verified R38 had not received tooth brushing this a.m. for his natural teeth. On 2/16/12, at 8:07 a.m. registered nurse (RN)-B stated the POC identified R38's mouth care twice daily. RN-B stated she would expect staff to brush the lower teeth according to the POC. At 10:55 a.m. the director of nursing verified the POC was not followed. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 565		
2 855	MN Rule 4658.0520 Subp. 2 E. Adequate and Proper Nursing Care;Oral Hygiene Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. Assistance as needed with oral hygiene to keep the mouth, teeth, or dentures clean. Measures must be used to prevent dry, cracked lips This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide adequate oral hygiene for 1 of 1 resident (R38) in the sample who had natural teeth and was dependent on staff for assistance with oral care.	2 855		

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2 855	Continued From page 7 Findings include: R38's diagnoses included organic brain syndrome. The annual Minimum Data Set (MDS) dated 11/15/11, identified R38 as having moderate cognitive impairment, and as requiring extensive assistance with personal hygiene. The current plan of care (POC) printed 2/15/12, identified R38 as having upper dentures and 6 bottom natural teeth. The plan of care directed the staff to remove dentures at bedtime and clean and soak them. In addition, staff were to encourage R38 to rinse and spit with mouth care twice daily. On 2/15/12, at 8:04 a.m. nursing assistant (NA)-A and NA-B provided morning cares for R38. At 8:25 a.m. NA-A stated R38's upper denture was placed after it had soaked all night. At 1:05 p.m. NA-B was told R38 had some natural teeth on the bottom. She stated she was not aware R38 had natural bottom teeth. NA-B stated R38 was given mouth wash in the a.m. She verified neither she nor NA-A had brushed R38's teeth. At 1:12 p.m. NA-B brought R38 to his room, and found that the resident had 6 teeth on the bottom. NA-B stated she had not known R38 had teeth on the bottom. NA-B stated staff probably assume since R38 has an upper denture, he has no teeth on the bottom. At that time, R38's bottom teeth were observed to have plaque build-up on them. NA-B verified R38 had not received tooth brushing this a.m. for his natural teeth. NA-B	2 855		

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2 855	Continued From page 8 stated the report sheet she carried in her pocket did not address the natural teeth or oral hygiene. At that time, in the bathroom medicine cabinet, a denture cleaning brush, toothpaste, and Efferdent were noted. However, there was no toothbrush in the bathroom. At 1:58 p.m. NA-C stated she did not know R38 had bottom teeth. She stated she had done R38's oral cares many time and knew he had a top denture. NA-C stated NA-B had just told her about R38's teeth and NA-B had just brushed them. NA-B had stated the teeth had a bunch of "gunk" in them and R38 needed oral hygiene. At 2:05 p.m. NA-C stated they have a "to do list" they print off each shift. She verified it did not address R38's oral hygiene or lower teeth. On 2/16/12, at 8:07 a.m. registered nurse (RN)-B stated the POC identified R38's mouth care twice daily. RN-B stated she would expect staff to brush the lower teeth according to the POC. At 10:55 a.m. the director of nursing verified the POC was not followed. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could insure that staff are re-inserviced as to their responsibility to provide oral care according to facility policy and then audit this service to insure that it is being provided as indicated and take action as needed. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 855		

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2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to accurately monitor skin integrity and ensure the resident received an appropriate individualized repositioning schedule to minimize the risk of pressure ulcer development for 1 of 2 residents (R69) in the sample with a pressure ulcer. Findings include: R69 was diagnosed with a recent cerebrovascular accident (stroke) and chronic kidney disease. The admission Minimum Data Set (MDS) dated 12/12/11, indicated that R69 had no cognitive impairment and required extensive assistance with bed mobility and total assist for transfers. The MDS further indicated R69 had no pressure ulcers (PU) but was at risk	2 900		

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	00579	A. BUILDING _____ B. WING _____	02/16/2012

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2 900	Continued From page 10 for the development of PUs determined through a formal and clinical assessment. R69 was identified to utilize a pressure relieving device for her wheelchair and bed as well as a repositioning schedule. The Pressure Ulcer Care Area Assessment (CAA) dated 12/21/11, indicated R69 was at risk for PUs due to risk factors including immobility, incontinence, recent decline in activities of daily living, and functional limitations in range of motion. Further risk factors included the diagnoses of cerebrovasular accident with hemiplegia (weakness of one side), depression, chronic or end-stage renal disease and pain. The Braden Scale (tool to predict pressure ulcer risk) dated 12/8/11, and 12/21/11, identified R69 as at risk for pressure ulcer development with a score of 13. The form indicated a score of 12 or less represented high risk for pressure ulcer development. The Checklist of Skin Risk Factors & Interventions dated 12/8/11, and 12/21/11, identified the Braden Scale results and included interventions of turning and repositioning every 2 hours and the use of pressure reduction support surfaces in bed and with sitting. However, the record lacked documentation to support the rationale for the 2 hour repositioning schedule. Review of the undated policy Skin Protocol, indicated that a Tissue Tolerance Assessment would be initiated if the Braden scale was 14 or below and that both bed and sitting position assessments were to be done. Additionally, the policy identified that if the most recent MDS identified the resident needed limited assistance or greater with transferring, a sitting position	2 900		

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2 900	Continued From page 11 Tissue Tolerance was to be done. If the resident was identified with limited assistance or greater with bed mobility, a bed Tissue Tolerance was to be done. The policy also identified the Braden Scale would be done on admission, quarterly, and with a significant change in status. The plan of care (POC) dated 1/19/12, indicated R69 was dependent on staff for turning and directed staff to reposition R69 every 2 hours and as needed, and provide a wheelchair cushion and a pressure relief mattress. The POC, revised at the time of the survey on 2/16/12, directed staff to provide R69 with an alternating pressure pad system to the bed. Review of the nursing progress notes indicated: On 12/8/11, the initial skin assessment indicated R69 had no areas of redness or skin breakdown. On 1/1/12, R69 had a 2 cm open "abrasion" on the left buttock cheek. The area was cleansed and Lyofoam and Duoderm (wound care products) were implemented. On 1/3/12, R69 had an open area on the left buttock with Cavilon and Duoderm (wound care products) re-applied. On 1/5/12, R69's open area was "about 2 cm." On 1/10/12, R69 continued to have a skin "abrasion" on the left buttock and R69 was repositioned every two hours. Further nursing notes indicated incomplete and sometimes conflicting documentation regarding R69's skin integrity with no indication when the "abrasion" was determined as resolved:	2 900		

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2 900	Continued From page 12 On 1/16/12, no "abrasion" or dressing could be found on R69 and the skin was left open to air. On 1/17/12, R69 had Duoderm on an "abrasion" on her coccyx with a pressure relief mattress on the bed and pressure relief cushion in the wheelchair. On 1/25/12, at 12:11 p.m. R69 was seen for skin rounds by the registered nurse (RN) and the physical therapy aide (PTA) with no problems noted on right or left buttocks. On 1/25/12, at 12:15 p.m. a pressure reducing air mattress was initiated after discussion at the facility's skin rounds identified R69 was at risk and would benefit from additional pressure prevention interventions. The nursing progress note dated 2/9/12, indicated R69 had developed a wound to the right of her coccyx. No further comprehensive skin assessment, including an assessment of R69's individual repositioning schedule, was noted in the clinical record at that time. Further nursing notes indicated: On 2/9/12, R69's wound on the right of her coccyx was .5 cm open. The area was cleansed and dried, with Cavilon spray, Polymen and Duoderm (wound care products) applied. On 2/13/12, at 4:50 p.m. R69 had a discolored area 2.6 cm X 3.2 cm, with a superficial open area 1.8 cm X 1.6 cm with tissue covering the center 0.3 cm.	2 900		

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2 900	Continued From page 13 On 2/13/12, at 11:45 p.m. R69 was identified with a pressure ulcer that was unstageable (known but not stageable due to the coverage of the wound by nonviable tissue) on her coccyx. Assessment by 2 RNs noted a measurement of 1.7 cm X 1.2 cm with a dark center and white perimeter with blanchable redness surrounding that was not measured. The area was noted as not open at present, and staff anticipated it would open with a plan to refer it to the facility's skin rounds. The facility's Tissue Tolerance Assessment form dated 2/14/12, indicated R69 was noted to have pink blanchable areas noted to buttocks and sacrum 2 hours after positioned lying that would clear when off loaded (repositioned) 1/2 hour. R69 was noted to have pink blanchable area noted to buttocks and sacrum at 2 1/2 hours after lying with pink blanchable area to hip. No Tissue Tolerance Assessment for seating and no admission assessment of lying could be found in the record. On 2/15/12, at 8:11 a.m. licensed practical nurse (LPN)-A was observed to assess R69's coccyx area. LPN-A stated the Duoderm which was observed to be loose needed to be changed. LPN-A completed the dressing change at 8:15 a.m. with the open area observed, but not measured. The tissue surrounding the open area appeared to have a dull/darker hue with minimal redness. On 2/15/12, at 8:27 a.m. R69 was transferred to the wheelchair via a mechanical lift to be taken out to the dining room for breakfast. On 2/15/12, at 9:38 a.m. R69 was taken back to	2 900		

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2 900	Continued From page 14 her room and transferred to bed to be seen for skin rounds by RN-A and PTA-A. PTA-A stated this was the first time the skin team was seeing R69 for this open area, but the resident had been seen a couple of weeks prior when there was a report that R69 had an area of redness on her coccyx. PTA-A stated at that time, there was no redness or open areas. At 9:44 a.m. PTA-A removed the Duoderm and measured the wound as 1.3 cm by 0.8 cm open. Redness was noted extending laterally from both edges of the open wound. RN-A and PTA-A decided to change the current treatment to Xerofoam (wound care product) covered by Duoderm. RN-A stated that clearly the Duoderm was not enough and that she would consider the area an unstagable pressure ulcer because of the slough on the wound and location. On 2/15/12, at 1:11 p.m. LPN-A stated she was not sure when the current PU started, but thought it was open on 2/11/12. On 2/16/12, at 8:49 a.m. RN-A stated that R69 had been identified as at risk for pressure ulcers on admission to the facility. RN-A stated that the initial "abrasion" reported on the buttocks had been reviewed with the director of nurses (DON). They had determined this was a result of R69 pulling herself towards the grab bars and creating shear, so the grab bars had been removed. RN-A stated this area was not considered a PU. RN-A stated the current PU was first reported on 2/9/12, with Polymen and Duoderm treatment started. RN-A added on 2/13/12, it was determined to be an unstagable PU. RN-A verified that there were two different set of measurements for 2/13/12, and stated this was because two different staff had done the	2 900		

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2 900	Continued From page 15 measurements. RN-A stated that interventions for the prevention of PUs for R69 included a turning and repositioning schedule of every 2 hours and as needed. RN-A stated that the Tissue Tolerance Assessment is what staff would have used to determine the timing of the repositioning needs for R69. However, RN-A verified there was no Tissue Tolerance Assessment done on admission for either the lying or sitting positions, and the assessment done 2/14/12, included only a lying assessment. On 2/16/12, at 10:30 a.m. the director of nurses verified R69 should have had a lying and sitting Tissue Tolerance Assessment completed as part of the comprehensive assessment based on facility policy. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review policies and procedures regarding care for residents at risk or with pressure ulcers, educate staff on pressure ulcers protocols and develop a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 900		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to	21390		

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21390	Continued From page 16 reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate infection control measures, related to proper hand hygiene and technique, were followed during wound cares for 2 of 2 residents (R8, R69) observed during a dressing change for which infection control practices to prevent cross contamination would have been indicated. Findings include: R69 was diagnosed with a recent cerebrovascular accident (stroke) and chronic kidney disease. The admission Minimum Data Set (MDS) dated 12/12/11, indicated that R69 had no cognitive impairment.	21390		

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21390	Continued From page 17 The nursing progress note on 2/9/12, indicated R69 had developed a wound to the right of her coccyx that was open 0.5 cm. Additionally on 2/13/12, the nursing progress notes identified this area as an unstageable pressure ulcer PU (known but not stageable due to the coverage of the wound by nonviable tissue) that was being treated with a duoderm dressing that was changed every three days and as needed. On 2/15/12, at 8:15 a.m. licensed practical nurse (LPN)-A was observed to complete a change of the Duoderm dressing for R69. LPN-A set the tray containing dressing supplies on R69's bedside table. LPN-A then donned nonsterile gloves and removed the loose Duoderm from R69's pressure ulcer and disposed of it into the garbage. At 8:16 a.m. LPN-A reached into the dressing tray without removing the soiled gloves and took out a packaged gauze dressing which she opened. LPN-A removed a bottle of saline from the tray which she opened and poured the saline onto the gauze dressing. LPN-A set the saline on the bedside stand and then used the wet gauze dressing to cleanse the pressure ulcer area. LPN-A then disposed of the gauze dressing into the garbage. LPN-A then reached into the tray with the same gloves and took out a Duoderm dressing and a pair of scissors which she used to cut a piece of Duoderm dressing. LPN-A put the unused Duoderm back into the tray and set the scissors on the bedside stand. At 8:17 a.m. LPN-A put the scissors back into the tray and placed the Duoderm dressing over R69's pressure ulcer. At 8:18 a.m. LPN-A replaced the cover on the	21390		

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21390	Continued From page 18 saline bottle and placed it into the dressing tray. LPN-A then removed her gloves and stood at the bedside to talk with the staff that were working with R69. LPN-A touched her face/nose and hair with her hands. At 8:23 a.m. LPN-A picked up the dressing tray and walked towards the door. LPN-A then placed the dressing tray down on the foot of R69's roommate's bed and went into the bathroom and washed her hands. At 8:24 a.m. LPN-A walked out of the room with the dressing tray. LPN-A stated that the dressing tray was used for other residents' dressing changes. On 2/15/12, at 1:11 p.m. LPN-A stated she should have removed her gloves after she took the old dressing off, and then wash her hands and put on new gloves. LPN-A stated she should not have reached into the tray for supplies with the soiled gloves after she had handled the old dressing. LPN-A stated that she had placed the dressing tray down on R69's roommate's bed because she did not know where a more appropriate place to put it would have been. LPN-A verified she had made several breaks in infection control techniques with the dressing change. On 2/16/12, at 8:49 a.m. RN-A verified staff had been trained to change their gloves between handling an old dressing and a new dressing and to complete hand hygiene in between. RN-A verified that staff had been instructed to not reach into the dressing supply tray with gloves that had been used during a dressing change. On 2/16/12, at 10:12 a.m. the director of nurses	21390		

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21390	Continued From page 19 (DON) was informed of the observations with the dressing change done by LPN-A on 2/15/12. She verified that LPN-A had not followed correct handwashing and infection control practices with the dressing change. The undated facility policy titled Dressing Changes directed staff to remove gloves after removing the old dressing and to wash hands. Additionally, staff were then to put on clean gloves to apply the new dressing, then remove gloves and wash hands. R8 was diagnosed with dementia. The quarterly MDS dated 1/24/12, indicated had 2 unstageable pressure ulcers (PUs) (not stageable due to coverage of the wound bed by slough and/or eschar). On 2/1/12, the Physician Orders indicated R8 would be started on antibiotic therapy for an infection to the right hip wound. On 2/15/12, at 10: 53 a.m. physical therapist (PT) -A was observed to provide wound care to R8. PT-A was observed to don 2 pair of gloves. At this time, PT-A stated she double gloved to save the need for handwashing in between removing the dirty dressing and applying the clean dressing. PT-A was then observed to remove the soiled dressing from R8's right hip wound. PT-A disposed of the soiled dressing and reached inside a container with dressing supplies and touched items in the container for the new	21390		

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21390	Continued From page 20 dressing. PT-A then removed her outer pair of gloves, which left one pair of gloves still on. PT-A was then observed to don a clean pair of gloves over the top of the gloves still on her hands. PT-A was observed to use a single use tool to debride (removal of dead tissue) R8's wound. PT-A then wiped off the debriding tool with a 2 x 2 bandage, and then placed the tool in the original container. PT-A applied the new dressing and then removed both gloves and cleansed her hands with an alcohol based cleanser. At 11:09 a.m. PT-A donned a clean pair of gloves and removed the soiled dressing from R8's coccyx wound. PT-A used the same debriding tool on the coccyx as she had used on the right hip. PT-A again wiped off the debriding tool with a 2 x 2 bandage and then placed the tool in the original container. PT-A was observed to touch the inside of the dressing supply container with her soiled gloves and touch various items in the box. PT-A cleansed the wound and then removed the soiled gloves. PT-A was observed to cleanse her hands with alcohol, apply new gloves, and then apply the new dressing. At 11:18 a.m. PT-A was observed to cleanse her hands with alcohol, apply new clean gloves and remove a dressing to R8's left gluteal crease. Without changing gloves, she removed the dressing from R8's left hip. PT-A stated at this time, she believed R8's right hip had been infected and the resident was on an antibiotic for the infection. At 11:21 a.m. PT-A used the same tool to debride	21390		

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21390	Continued From page 21 the left hip. PT-A wiped off the debriding tool with a 2 x 2 bandage, then placed the tool in the original container. PT-A removed her gloves and cleansed her hands with alcohol and placed new gloves. PT-A obtained the dressing supplies out of the same container in which she had touched the supplies with her soiled gloves to obtain the new dressings. PT-A applied the new dressing to the left gluteal fold and the left hip. PT-A then removed her soiled gloves and cleansed her hands with alcohol. At 11:29 a.m. PT-A applied new gloves and removed the dressing on the left side of R8's back. PT-A used the same tool, used on the previous wounds, to debride the wound. She then wiped it off with a 2 x 2 and placed in the same container. PT-A then removed her gloves, cleansed her hands, and applied new gloves. PT-A obtained the dressing and applied the clean dressing. Next, PT-A removed the soiled dressing to the wound on the left scapula without changing her gloves. PT-A stated she noted a strong smell from the wound. The wound was observed to be red and inflamed with drainage. Initially, the PT stated she thought the wound needed to be cultured. PT-A reached in the supply container with her soiled gloves to obtained items to cleanse the wound. The PT used the same debriding tool as she had used on all the other wounds to debride the wound. PT-A removed her gloves, cleansed her hands, and placed new gloves. The PT stated the wound did not smell as strong as it did after she cleansed it. The PT applied the new dressing to the wound. PT-A removed her gloves and cleansed her hands when she was completed with wound care. At 11:53 a.m. PT-A stated she double gloves to	21390		

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21390	Continued From page 22 save on one hand wash between removing the dirty dressing and applying the new dressing. She stated they have been told they could do that, and the practice is part of the hospital wide policy. PT-A stated she uses the debriding tool on all wounds and felt this was okay because it was used on the same resident. She stated she was not concerned about cross contamination because the organism was internalized so the same organisms would be in every wound. PT-A added R8 is on an antibiotic so that would cover any infection. On 2/16/12, at 11:34 a.m. the director of nursing (DON) stated double gloving does not follow the policy. The DON added she did not think using the same tool on each wound would be following the policy either. The DON agreed that it is not good infection control practice to touch the inside of the wound supply box with dirty gloves. The undated facility policy titled Dressing Changes directed staff to remove gloves after removing the old dressing and to wash hands. Additionally, staff were then to put on clean gloves to apply the new dressing, then remove gloves and wash hands. Suggested Method of Correction: The administrator or designee could review policies and procedures to ensure proper infection control techniques are followed. Facility staff could be reeducated and an auditing system developed to ensure compliance. Time Period for Correction: Twenty one (21) days.	21390		

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	00579	A. BUILDING _____ B. WING _____	02/16/2012

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21530	Continued From page 23	21530		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee.	21530		

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21530	Continued From page 24 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure an irregularity, related to an antidepressant medication used for insomnia without adequate monitoring of it's effectiveness, was reported by the pharmacist to the resident's physician and the director of nursing for 1 of 10 residents (R31) in the sample reviewed for unnecessary medications. Findings include: R31 was diagnosed with dementia, insomnia, depression, and anxiety. The quarterly Minimum Data Set (MDS) dated 1/17/12, identified R31's cognitive impairments and as having trouble falling or staying asleep several days. The current physician's orders indicated Remeron 7.5 mg was initiated on 8/31/10, for insomnia. However, the medical record lacked a sleep log or documentation to indicate R31's insomnia or sleep patterns had been monitored except for the month of December 2011. At that time, two entries were documented on the behavior monitoring record. Further review of the physician's orders indicated R31 had received an order to initiate another antidepressant (Celexa 20 mg. every day) on 3/3/11, for increasing agitation, restless, increase in repetitive questions and not sleeping well at night. This medication was decreased on 9/14/11, to Celexa 10 mg. every day with no problems noted. The pharmacist's monthly drug regimen review	21530		

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21530	Continued From page 25 dated 1/19/12, failed to identify and report R31's sleep patterns had not been monitored. The pharmacist noted R31 had been hitting, swearing and trying to hit. The pharmacist indicated he/she would be reluctant to ask for "psych. meds reduction." On 2/16/12, at 9:50 a.m. the pharmacist's reviews were reviewed with registered nurse (RN)-B. RN-B verified R31 received Remeron for insomnia and the record lacked documentation R31's sleep pattern had been monitored except in December 2011. SUGGESTED METHOD FOR CORRECTION: The administrator, director of nursing and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. Staff could be educated as necessary. The director of nursing or designee could monitor medications on a regular basis to ensure compliance with state and federal regulations. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21530		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist	21540		

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21540	Continued From page 26 believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to adequately monitor sleep patterns to determine the effectiveness and continued use of an antidepressant medication used for insomnia for 1 of 10 residents (R31) in the sample reviewed for medication use. Findings include: R31 was diagnosed with dementia, insomnia, depression, and anxiety. The quarterly Minimum Data Set (MDS) dated 1/17/12, identified R31's cognitive impairments and as having trouble falling or staying asleep several days. The MDS indicated R31 required total assistance from staff with all activities of daily living. The current physician's orders indicated Remeron 7.5 mg was initiated on 8/31/10, for insomnia. However, the medical record lacked a sleep log or documentation to indicate R31's insomnia or sleep patterns were monitored except for the month of December 2011. At that time, two	21540		

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21540	Continued From page 27 entries were documented on the behavior monitoring record. Further review of the physician's orders indicated R31 had received an order to initiate another antidepressant (Celexa 20 mg. every day) on 3/3/11, for increasing agitation, restless, increase in repetitive questions and not sleeping well at night. This medication was decreased on 9/14/11, to Celexa 10 mg. every day with no problems noted. On 2/16/12, at 9:50 a.m. registered nurse (RN)-B verified R31 received Remeron for insomnia and the only documentation related to R31's sleep patterns was on the December 2011 behavior monitoring record. The facility's psychotropic medication monitoring policy dated 4/10 indicated a sleep log would be completed quarterly in coordination with the MDS. F329 SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or designee could conduct random audits of resident psychotropic medication regimens to ensure the required state and federal regulatory requirements are implemented and that residents receive appropriate monitoring of medications. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21540		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults	21995		

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21995	Continued From page 28 Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure an allegation of potential mistreatment during a bath had been thoroughly investigated for 1 of 4 resident (R4) reviewed with an allegation of mistreatment. Findings include: The Abuse and Neglect policy revised 6/09, directed staff to conduct an internal investigation of any suspected maltreatment of a Vulnerable adult. The components of the investigation included: interviewing appropriate staff involved in the incident, deciding if a safety plan was needed, gathering appropriate information on the suspected perpetrator including a work history, and determining whether there had been past allegations of maltreatment. R4 was diagnosed with dementia with behavior disturbances and depression. The quarterly Minimum Data Set (MDS) dated 6/21/11, identified R4 as cognitively intact. The MDS also indicated R4 required total assistance from staff with all activities of daily living.	21995		

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21995	Continued From page 29 The progress note dated 6/13/11, indicated R4 was very agitated and had accused the staff that had completed R4's bath as being rough and mean. R4 had also stated, "My hip hurts today because of it." The allegation was reported immediately and an internal investigation assessment and evaluation form was completed. The description of the investigation noted, "follow-up reveals staff followed protocol with bath, no mistreatment identified during bathing process" and that the staff working the evening shift of 6/12/11, had stated R4 "was very angry with bath, hitting, swearing, and etc." However, the internal form lacked documentation to determine if the allegation was substantiated, including who was interviewed, when the interviews took place, and what was stated by the staff interviewed. On 2/16/12, at 8:30 a.m. the director of nursing (DON) stated the perpetrators were interviewed separately and the stories matched, however, the investigation report lacked that information. SUGGESTED METHOD FOR CORRECTION: The administrator, DON, social services or designee(s) could review and revise as necessary the policies and procedures regarding the internal process of reporting/investigating the process of abuse or mistreatment. The administrator, DON, social services or designee (s) could provide training for all appropriate staff on these policies and procedures. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21995		

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