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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: P5BD

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00619

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245473**

2.STATE VENDOR OR MEDICAID NO.
(L2) **747642000**

3. NAME AND ADDRESS OF FACILITY
(L3) **OAK TERRACE HEALTH CARE CENTER**
(L4) **640 THIRD STREET**
(L5) **GAYLORD, MN** (L6) **55334**

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 **1/16/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)

0 Unaccredited 1 TJC
2 AOA 3 Other

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **48** (L18)

13.Total Certified Beds **48** (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	IID
	48			
(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 :
Mary Rogers, HPR Social Work Specialist — 01/06/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 01/17/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **05/01/1987** (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
Posted 3/31/2014 ML

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
01/22/2014 (L33)

DETERMINATION APPROVAL

Page 2
Provider Number: 24-5473
Item 16 Continuation for CMS-1539

Standard surveys were completed at this facility on January 31, 2013 and November 22, 2013. At the time of the January 31, 2013 the most serious deficiency was cited at a S/S level of G. At the time of the November 22, 2013 survey, the most serious deficiency was cited at a S/S level of G, therefore the facility met the criterion for a No Opportunity to Correct. As a result of the survey findings, this Department imposed state monitoring effective December 21, 2013. In addition, we recommended to the CMS RO that the following enforcement remedy be imposed and CMS concurred:

- Civil money penalty for the deficiency cited at F314

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. PCR restores facility to substantial compliance, state monitoring was terminated December 18, 2013 Effective December 19, 2013, the facility is certified for 48 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245473

March 14, 2014

Ms. Deborah Barnes, Administrator
Oak Terrace Health Care Center
640 Third Street
Gaylord, MN 55334

Dear Ms. Barnes:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective December 19, 2013, the above facility is certified for:

48 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 48 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

February 2, 2014

Ms. Deborah Barnes, Administrator
Oak Terrace Health Care Center
640 Third Street
Gaylord, Minnesota 55334

RE: Project Number S5473024

Dear Ms. Barnes:

On December 13, 2013, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective December 21, 2013. (42 CFR 488.422)

On December 13, 2013, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedies be imposed:

- Civil money penalty for the deficiency cited at F314. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for a standard survey completed on November 21, 2013. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On January 16, 2014, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 21, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 19, 2013. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 21, 2013, as of December 19, 2013.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective December 19, 2013.

In addition, this Department is recommending to the CMS Region V Office the following actions related to the imposed remedies in our letter of December 16, 2013:

- Civil money penalty for the deficiency cited at F314 will remain in effect. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedy, and appeal rights.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5473r14.rtf

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
245473	A. Building B. Wing	1/16/2014

Name of Facility	Street Address, City, State, Zip Code
OAK TERRACE HEALTH CARE CENTER	640 THIRD STREET GAYLORD, MN 55334

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 **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **12/19/2013**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **12/19/2013**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **11/21/2013**
ID Prefix **F0281** Reg. # **483.20(k)(3)(i)** LSC	Correction Completed **12/19/2013**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **12/19/2013**	ID Prefix **F0320** Reg. # **483.25(f)(2)** LSC	Correction Completed **12/19/2013**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **11/21/2013**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **12/19/2013**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/SG	02/02/2014	29437	01/16/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
11/21/2013			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: P5BD

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00619

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245473**
2.STATE VENDOR OR MEDICAID NO.
(L2) **747642000**

3. NAME AND ADDRESS OF FACILITY
(L3) **OAK TERRACE HEALTH CARE CENTER**
(L4) **640 THIRD STREET**
(L5) **GAYLORD, MN** (L6) **55334**

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 **11/21/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **48** (L18)

13.Total Certified Beds **48** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	48			
(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 :
LoAnn Degagne, HFE NE II 01/06/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 01/17/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN# 24-5473

Standard surveys were completed at this facility on January 31, 2013 and November 22, 2013. At the time of the January 31, 2013 the most serious deficiency was cited at a S/S level of G. At the time of the November 22, 2013 survey, the most serious deficiency was cited at a S/S level of G, therefore the facility met the criterion for a No Opportunity to Correct. As a result of the survey findings, this Department imposed state monitoring effective December 21, 2013. In addition, we recommended to the CMS RO that the following enforcement remedy be imposed and CMS concurred:

- Civil money penalty for the deficiency cited at F314

See attached CMS-2567 forms for the November 22, 2013 survey.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7002 0860 0006 5192 3742

December 16, 2013

Ms. Deborah Barnes, Administrator
Oak Terrace Health Care Center
640 Third Street
Gaylord, Minnesota 55334

RE: Project Number S5473024

Dear Ms. Barnes:

On November 22, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby significant corrections are required. A copy of the Statement of Deficiencies (CMS-2567 and/or Form A) is enclosed.

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

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

Potential Consequences - the consequences of not attaining substantial compliance 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:

Sarah Grebenc, Unit Supervisor
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557

Phone: (320) 223-7365
Fax: (320) 223-7348

NO 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 they have deficiencies of actual harm or above cited at the current survey, and on the previous standard or intervening survey (i.e. any survey between the current survey and the last standard survey). A level G deficiency (isolated deficiencies that constituted actual harm that was not immediate jeopardy), whereby significant corrections were required was issued pursuant to a survey completed on January 31, 2013. The current survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G). Your facility meets the criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective December 21, 2013. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

Civil money penalty for the deficiency cited at F314 (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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 remedy be imposed:

• 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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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.

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 February 21, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 21, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File

5473s14.rtf

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245473	A. BUILDING _____ B. WING _____	11/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TERRACE HEALTH CARE CENTER	640 THIRD STREET GAYLORD, MN 55334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	Initial Comments: This plan of correction constitutes our written allegation of compliance for the deficiencies listed. However, submission of the plan of correction is not an admission that a deficiency exists. This plan of correction is submitted to meet requirements established by the state and federal law.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in	F 157	RECEIVED DEC 24 2013 MN Dept of Health St. Cloud F157 Corrective Action: Resident 49 Per resident care plan, resident will be turned and repositioned every 2 hours or based on Tissue Tolerance Testing. Skin will be observed twice a day with a.m. and p.m. cares for any signs of breakdown in skin and if any changes were noted the charge nurse was to be notified immediately and charge nurse will be notifying provider of any skin concerns, either by fax or phone.	

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

Deborah Barnes Adm 12-23-13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245473	A. BUILDING _____ B. WING _____	11/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TERRACE HEALTH CARE CENTER	640 THIRD STREET GAYLORD, MN 55334

(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 157	Continued From page 1 resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately notify the physician for 1 of 1 resident (R49) reviewed, who had a change in condition when she developed a pressure ulcer. Findings include: R49 was admitted on 7/1/13. R49's admission Minimum Data Set (MDS), dated 7/14/13, indicated R49's cognitive skills were severely impaired. R49 required extensive assistance for bed mobility, transfers, personal hygiene, and toilet use. The MDS assessment identified R49 was at risk for the development of pressure ulcers. The MDS also identified R49 had diagnoses that included diabetes type 2, dementia, urinary incontinence, congestive heart failure, and unspecified closed fracture of the left ankle. The Care Area Assessment (CAA) completed on 7/13/13, identified R49 was at risk for pressure ulcer development due to needing extensive assistance with mobility, frequent incontinence of bowel and bladder, altered mental status, the use of antidepressants, and diagnoses including diabetes and congestive heart failure. R49 was to be repositioned every two hours and her skin was	F 157	F 157 Systems Correction: On 12/18/13 a staff meeting was held for all floor staff to attend, and they were educated by the DON on turning and repositioning the resident per closet care plan, staff that was not in attendance was educated independently by DON. This will be completed by 12/19/13. The DON has printed the Oak Terrace policy regarding MD notification. (Attachment E) All licensed staff was individually instructed by the DON and were required to read the policy and sign when completed. Providers will be notified per policy guidelines.DON will be auditing charts for follow up regarding resident fax/MD notification forms, this will be done weekly times 4, then monthly times 11 months, and thru the QAPI process quarterly. This was completed on 12/19/13. The DON is responsible to ensure that all new staff is made aware of the policy, making this part of orientation process by including it in the orientate checklist; (Attachment B) at the end of the orientation process the orientating charge nurse will sign off on the orientation check list and this is given to the DON to ensure the staff has had adequate orientation.	

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F 157	Continued From page 2 to be observed twice a day with a.m. and p.m. cares for any signs of breakdown in skin, and if any changes were noted, the charge nurse was to be notified immediately. Review of the Skin Collection Tool, dated 7/1/13, indicated R49 had a scab on the right lower leg that measured .6 centimeters (cm) x .2 cm, a right forearm skin tear that measured 1 cm x .6 cm, a right forearm skin tear that measured .5 cm x .5 cm, a bruise on the right forearm that measured 1.3 cm x 1.4 cm, a scab on the front of the left knee that measured 1.2 cm x .2 cm, a bruise of the left hip that measured 3 cm x 3 cm, a "vascular" on the left buttock that measured .5 cm x .6 cm, and a bruise on the right hip that measured 3 cm x 2.5 cm. There was no evidence of an alteration in skin integrity on the left foot.	F 157	Charts will be audited by the DON for MD notifications regarding resident changes in condition; this audit will be completed weekly times 4 weeks, then monthly times 12 months. The audits will be a part of the QAPI process quarterly.	
	On 7/5/13, at 10:53 a.m. a progress note indicated, "Weekly diabetic foot check done this shift...On the top of the (L) foot there is a 7 cm x 8 cm reddened area that ascends up the second toe with a 1 cm x 0.7 cm scabbed area on the middle of that second toe...resident expressed tenderness and pain with palpation of this area." On 7/5/13, at 10:57 a.m. a progress note indicated a fax was prepared for physician assistant certified (PAC)-A to address the reddened area on R49's left foot. Review of a Problem Sheet to R49's physician, dated 7/5/13 at 11:00 a.m., included a description of the area on the (L) foot as noted above. There was no documentation or evidence to indicate the physician or PAC-A responded to this until 7/9/13, when PAC-A made a routine visit to the facility. Orders from PAC-A on 7/9/13, included, "Needs to be seen...Levaquin 500 mg [one by mouth] daily x 10 days. Dx [diagnosis]: Cellulitis...Clean			

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F 157	Continued From page 3 ulcerated area with wound cleanser. Pat dry. Apply Repara Hydrocolloid to wound. Dx: Pressure ulcer L 2nd toe...Recheck ulcer and cellulitis on 7/11/13." During an interview on 11/21/13, at 4:20 p.m. PAC-A stated she was not aware of the ulcer on R49's left foot until she saw her on 7/9/13, when she visited the facility. PAC-A verified, according to the fax, the charge nurse sent information regarding the area on the left foot and 2nd toe on 7/5/13, at 11:00 a.m. to R49's physician. There was no evidence that the physician responded to the fax or that the facility staff attempted to contact the physician when no response was received. PAC-A stated, "If this is what it looked like, it should have been handled a little more aggressively." During an interview on 11/21/13, at 4:43 p.m. director of nursing (DON) stated, "The order should have been addressed with more urgency." A review of The Change in Resident's Condition or Status policy, reviewed/revised 6/12, included the facility " shall promptly notify the resident, his or her attending physician, and representative of changes in the resident's condition and/or status. " Also included, "the nurse supervisor will notify the resident's attending physician when ...There is a significant change in the resident's physical, mental, or psychological status ...Except in medical emergencies, notifications will be made within 24 hours of a change occurring in the resident's condition or status. "	F 157		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		

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F 279	Continued From page 4 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop care plan interventions for 1 of 1 resident (R69) reviewed for behavior interventions identified by a licensed independent clinical social worker (LICSW). Findings include: R69 was admitted to the facility on 8/5/13, and according to the physician orders of 10/7/13, R69 had a diagnosis which include depressive disorder not elsewhere classified. The Care Area Assessment (CAA) completed on	F 279	**Tag** F 279 SS=D- Develop Comprehensive Care Plans **A.) Resident Focus:** Resident was discharged. If he had not been discharged these are the steps that would have been implanted. Per directive of the closet care plan CNA's, Activities, Licensed Nurse, and/or Social Services will have 1:1 sessions with resident to discuss symptoms once a week until resident's symptoms are less frequent. Social Services will monitor task list weekly x4 and monthly x11 to assure compliance by staff. **B.) Corrective Action:** Social Services will review the LICSW recommendations and integrate recommendations in to the residents closet Care Plan and the Point of Care Care Plan. Social Services will make a note on the Point of Care homepage to make licensed staff aware of the new interventions. Social Services will audit both closet and Point of Care Care Plans and make changes according to intervention recommendations and/or symptoms. During	

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F 279	Continued From page 5 8/12/13, identified cognitive loss/dementia, psychosocial well-being, mood and behavioral symptoms as actual problems for R69. The assessment indicated for all care areas that the resident will be cued and prompted by staff. Resident diagnosed with depression disorder. Resident will be redirected by staff when resident shows signs of inattention and disorganized thinking. Resident will be offered activities throughout day. R69 was seen for a diagnostic assessment by a consulting licensed social worker (LICSW) on 8/5/13. As a result of the assessment, recommendations were made for the resident to be seen by his personal physician as soon as possible to review his pain medication and for his personal physician to consider use of an antidepressant simultaneously to treat pain and mood. In addition, it was recommended the resident liked "BS'ing" even if not into [the] program and responded well when out in the public area socializing [with others] and it was important for the resident to staying meaningfully involved as during these times, the focus on pain diminished. She recommended for the resident's physician to decide to increase pain medication and to consider a pain clinic. She recommended the 15 minute safety checks were not needed but his room was to be secure and to work with him around the common goals of reducing his suffering (pain, etc.) and convey hope that he won't be alone and can improve. R69 was seen by the LICSW on 8/27/13, with no further recommendations. He was seen again on 9/5/13, with recommendation that occupational therapy evaluate the potential use of his motorized wheelchair, consultation with physician	F 279	the QAPI process Social Services will express concerns and request for recommendation from QAPI team on a quarterly basis. Social Services will communicate with family to discuss all interventions either by holding a Care Conference or by phone. The care plan will be reviewed during the residents quarterly. **C.) Plan of Action:** Social Services will measure symptoms by using the BIMS and PHQ9 assessments as well monitor symptoms by adding it to the Point of Care for staff to chart during the 14 day, Quarterly, and Comprehensive assessments. Social Services will review symptoms and have 1:1 sessions with resident to discuss the symptoms. date of correction 12/19/13 per phone conversation with DON & Social Worker on 1/6/14	

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F 279	Continued From page 6	F 279		

regarding a proposed plan to allow R69 to leave the facility for outings and to have discussion regarding the risks of R69 possibly having a beer with a friend and his checking in with staff. She also recommended that discussion of the resident possibly transitioning to assisted living setting as this might be an effective step toward independence and would likely improve his mood.

The resident's care plan was established 8/23/13, identified a problem area in which R69 made verbal suicidal threats with no prior attempts. He had reported he had a gun at his home that he would use on himself. The goal was established to maintain his safety and to eliminate or reduce his suicidal tendencies. Staff were instructed to document a summary of each episode and to document a change in the resident's affect. They were also instructed to notify social services when the resident made any suicidal threats.

The care plan lacked the recommendations from the LICSW. The goals of the care plan were not measurable and there was no evidence that monitoring of the problems areas had occurred. In addition, the care plan lacked specific interventions the nursing staff could implement for behavior management. The plan of care also did not specify a specific plan that would be implemented if the resident became suicidal or thoughts of self-harm.

An interview with the facility social worker (SW) was completed on 11/20/13, at 11:37 a.m. she reported the resident has a lot of behaviors and used a lot of profanity in his conversations. She indicated the resident had a lot of arguments with staff and other residents and then will deny that anything happened. She also reported he had

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F 279	Continued From page 7 posted notes he had written which were very profane and offensive to other residents and would post them on his bedroom door. She indicated the resident was being seen by a consulting psychologist "a couple times a month" to attempt to address his behaviors. The social worker did not identify how the staff was made aware of the LICSW's recommendations or how those recommendations were implanted on the care plan.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 280		

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F 280	Continued From page 8 review, the facility failed to ensure resident care plan was revised and updated when there was a change in resident's condition for 1 of 3 residents (R46) reviewed with change in condition. Findings include: R46 fell on 11/1/13, and sustained an injury of a fractured right fibula (a bone in the leg which extends from the knee to the ankle). The care plan, dated 1/23/12, indicated R46 had a potential for alteration in safety related to a history of cerebral vascular accident (CVA) or stroke with hemiparesis (weakness on one side of the body), as evidenced by the assistance required in transfers, wheelchair locomotion, and bed mobility. Mobility addressed in the care plan dated 1/23/12, indicated under interventions, "Please use one person assist along with EZ stand [a mechanical lift used for transfers] for all transfers, toileting and self-care/activities of daily living and make sure she is pushing up with her left arm and leg." Physician's visit note dated 11/13/13, indicated, "WBAT [weight bearing as tolerated] in boot with walker, may remove boot - only needed when ambulating, OT/PT [occupational therapy/physical therapy] for R [right] ankle strength / ROM [range of motion], follow up in three weeks." Therapy communication dated 11/19/13, indicated "Perform all transfers with EZ stand. Remind her to stand up tall. Please have Cam Boot [a boot to support the foot or ankle after injury] on for all transfers at this time. " During an observation on 11/20/13, at 8:37 a.m.	F 280	F 280 Corrective Actions: Resident 46 Residents Care plan was updated at the time of the survey visit when it was noted missing. This was done on 11/21/13, per MDS nurse. F 280 Systems Corrective Action: MDS nurse was educated per DON on updating the care plan with any changes from providers; this was completed on 11/21/13. To provide those changes to the staff on the closet care plan as well as report. The DON/ADON will monitor provider changes that are in writing that the changes are then put in the care plan. Monday –Friday in absence of DON, ADON will complete audit. On weekends the charge nurse will audit charts. Audits of charts will be completed weekly and be a part of the quarterly QAPI process. This has been corrected on 11/21/13.	

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F 280	Continued From page 9 R46 was being transferred off the toilet by nursing assistant (NA)-C, with the EZ stand. R46 was informed she would be raised up, however was not prompted to stand up straight. R46 was then placed in her recliner, visibly leaning to the right. Her Cam boot was not removed after being placed in the recliner. When interviewed on 11/20/13, at 8:45 a.m. NA-C indicated R46 was recently changed to transfer with the EZ lift with assist of one staff, that they are always to have the boot on during transfers, leave it on during the day, and remove it at night. She stated she was not aware of any other special instructions. When interviewed on 11/20/13 at 12:30 p.m., registered nurse (RN)-B indicated after a fall, recommendations are placed on the Fall Scene Investigation Report which is sent to the director of nursing (DON), administrator, social worker, and the Minimum Data Set (MDS) nurse. She also indicated the MDS nurse is responsible for updating the care plan as well as the "closet" care plan which is kept in the residents' rooms. She revealed communication of changes to the nursing assistants is through these forms, shift report, and a communication book. When interviewed on 11/21/13, at 8:33 a.m., NA-D revealed the "closet" care plan indicated R46 was to be transferred with the EZ stand, but there was nothing noted on this about the Cam boot. She also verified this was last signed off as being updated 4/4/13. NA-D stated the boot is to be left on when in the chair after a transfer. When interviewed on 11/21/13, at 9:32 a.m. RN-C indicated R46 is now using the EZ lift for	F 280		

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F 280	Continued From page 10 transfers. Any changes from therapy are in the form of a therapy note, which the charge nurse puts in a progress note. She indicated the nursing assistants should be following this because it is in the communication book or passed on through report. She indicated the nursing assistant or charge nurse would update the "closet" care plan, which should be checked weekly. She verified it was last updated 4/4/13. She verified the boot should be noted on the "closet" care plan. RN-C stated she was not sure if anything was changed on the care plan after the fall on 11/1/13. She verified the care plan did not mention the Cam boot. When interviewed on 11/21/13, at 10:50 a.m. physical therapist (PT)-A indicated R46 was to be transferred with the EZ stand and the Cam boot on. She revealed they only give recommendations, and do not write anything in the care plans. When interviewed on 11/21/13, at 1:30 p.m. NA-E indicated R46 transfers with the EZ stand and wears the boot during transfers, but was not aware of anything further. When interviewed on 11/21/13, at 2:30 p.m. the director of nursing (DON) verified the care plan made no mention of the Cam boot. She indicated the "closet" care plan was a tool, and not a part of the care plan. She also indicated it would be her expectation the care plans would be up to date. When interviewed on 11/21/13, at 4:30 p.m. the DON indicated the facility does not have a policy related to care plans.	F 280		
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET	F 281		

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F 281 SS=D	Continued From page 11 PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a temporary care plan at time of admission to identify interventions for pressure ulcer prevention to minimize skin breakdown for 1 of 1 resident (R49) identified to be at risk for pressure ulcers. Findings include: R49 was admitted on 7/1/13. R49's admission Minimum Data Set (MDS), dated 7/14/13, indicated R49's cognitive skills were severely impaired. R49 required extensive assistance for bed mobility, transfers, personal hygiene, and toilet use. The MDS assessment identified R49 was at risk for the development of pressure ulcers and further identified R49 had diagnosis that included type 2 diabetes, dementia, urinary incontinence, congestive heart failure, and unspecified closed fracture of the left ankle. The Care Area Assessment (CAA) completed on 7/13/13, identified R49 was at risk for pressure ulcer development due to needing extensive assistance with mobility, frequent incontinence of bowel and bladder, altered mental status, the use of antidepressants, and diagnoses including diabetes and congestive heart failure. R49 was to be repositioned every two hours and her skin was to be observed twice a day with a.m. and p.m. cares for any signs of breakdown in skin, and if	F 281	F281 Corrective Action: Resident 49 Per resident care plan, resident will be turned and repositioned every 2 hours or based on Tissue Tolerance Testing. (Attachment E) Skin will be observed twice a day with a.m. and p.m. cares for any signs of breakdown in skin and if any changes were noted the charge nurse was to be notified immediately and charge nurse will be notifying provider of any skin concerns, either by fax or phone. F281 System Corrective Action: Staff nurses were educated per DON on temporary closet care plans for the residents, addressing interventions for pressure ulcer prevention to minimize skin break down. Standard of care at Oak Terrace is that residents will be monitored for skin changes twice daily in a.m. and p.m. cares and that CNA staff will then report changes to the charge nurse and the charge nurse will then report to provider. (See Attachment C) The DON will monitor the temporary care plans weekly x4 then monthly times 11. To ensure that staff address Skin Care Audits of charts will be completed and be a part of the quarterly QAPI process. This has been corrected on 12/19/13.	

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F 281	Continued From page 12 any changes were noted, the charge nurse was to be notified immediately. R49's plan of care, initiated 7/21/13, included alteration in skin integrity and mobility but did not include interventions for pressure ulcer prevention. There was no evidence that a temporary care plan was developed or made available to staff when R49 was admitted to identify interventions for pressure ulcer prevention. During an interview on 11/21/13, at 4:43 p.m. director of nursing (DON) verified there were no interventions on the POC to prevent further pressure ulcers, stating, "We have a turning and repositioning plan but I would expect to see that on the care plan." DON verified that pressure ulcers were triggered on the CAA, and stated, "It didn't get carried to the care plan." A request was made for a plan of care policy. DON stated, "We don't have one."	F 281		
F 314 SS=G	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	F 314		

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F 314	Continued From page 13 by: Based on interview and document review, the facility failed to implement interventions to minimize skin breakdown for 1 of 3 residents (R49) reviewed for pressure ulcers. This resulted in actual harm for R49 who acquired three pressure ulcers while in the facility, one of which progressed to Stage 4 (full thickness tissue loss with exposed bone, tendon or muscle), and resulted in the resident being scheduled for surgical amputation of the digit. Findings include: R49 was admitted on 7/1/13, and the admission Minimum Data Set (MDS), dated 7/14/13, indicated R49's cognitive skills were severely impaired. R49 required extensive assistance for bed mobility, transfers, personal hygiene, and toilet use. The MDS assessment identified R49 was at risk for the development of pressure ulcers. The MDS also identified R49 had diagnoses that included type 2 diabetes, dementia, urinary incontinence, congestive heart failure, and unspecified closed fracture of the left ankle. The Care Area Assessment (CAA) completed on 7/13/13, identified R49 was at risk for pressure ulcer development due to needing extensive assistance with mobility, frequent incontinence of bowel and bladder, altered mental status, the use of antidepressants, and diagnoses including diabetes and congestive heart failure. R49 was to be repositioned every two hours and her skin was to be observed twice a day with a.m. and p.m. cares for any signs of breakdown in skin, and if any changes were noted, the charge nurse was to be notified immediately.	F 314	F 314 Corrective Actions: Resident 49 Per resident care plan, resident will be turned and repositioned every 2 hours or based on Tissue Tolerance Testing. (Attachment D) Skin will be observed twice a day with a.m. and p.m. cares for any signs of breakdown in skin and if any changes were noted the charge nurse was to be notified immediately and charge nurse will be notifying provider of any skin concerns, either by fax or phone. Staff nurses were educated per DON on temporary closet care (Attachment C) plans for the residents, addressing interventions for pressure ulcer prevention to minimize skin break down. Standard of care at Oak Terrace is that residents will be monitored for skin changes twice daily in a.m. and p.m. cares and that CNA staff will then report changes to the charge nurse and the charge nurse will then report to provider. The DON will monitor temporary care plans so that they address Skin Care Audits of charts will be completed and be a part of the quarterly QAPI process. This has been corrected on 12/19/13.	

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F 314	Continued From page 14 A review of the Braden Scale for Predicting Pressure Sore Risk tool, dated 7/1/13, indicated R49 was a "low risk" with a score of 17. Review of the admission Skin Collection Tool, dated 7/1/13, indicated R49 a "vascular" on the left buttock that measured .5 cm x .6 cm. There was no evidence that a temporary care plan was developed or made available to staff when R49 was admitted. R49's plan of care, that was initiated 7/21/13, included alteration in skin integrity and mobility but did not include interventions for pressure ulcer prevention such as pressure redistribution devices for bed or chair, turning and positioning schedule, or other nursing interventions to prevent pressure ulcers. The POC only included the dressing treatment for the pressure ulcers and arginade to increase protein. Review of the admission progress note, dated 7/1/13 at 10:25 p.m., indicated R49's "Skin and color was normal (pink)..." A history and physical completed by the physician assistant certified (PAC)-A, dated 7/2/13, indicated R49 was brought to the facility for skilled nursing care and rehabilitation after a left ankle fracture. Upon physical examination, R49's skin was "smooth, no lesions, purpura [purple] or abnormal moles noted," and examination of R49's extremities indicated, "peripheral pulses 2+, no cyanosis [blue or purple coloration of the skin or mucous membranes due to the tissues near the skin surface having low oxygen] clubbing, or deformities noted. CAM boot [type of air boot] on left lower leg."	F 314	The DON has printed the Oak Terrace policy regarding MD notification. (Attachment E) All licensed staff was individually instructed by the DON and were required to read the policy and sign when completed. This was completed on 12/19/13. The DON is responsible to ensure that all new staff is made aware of the policy, making this part of orientation process by including it in the orientate checklist. Charts are audited by the DON for MD notifications regarding resident changes in condition. The audits will be a part of the QAPI process quarterly.	

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F 314	Continued From page 15 Review of progress notes, dated 7/3/13, at 9:20 p.m. indicated "Day shift reported there may be a sore on her right buttock but no sore was noted at hs [hours of sleep] cares." On 7/5/13, at 10:53 a.m. a progress note indicated, "Weekly diabetic foot check done this shift...On the top of the (L) foot there is a 7 cm x 8 cm reddened area that ascends up the second toe with a 1 cm x 0.7 cm scabbed area on the middle of that second toe...resident expressed tenderness and pain with palpation of this area." On 7/5/13, at 10:57 a.m. a progress note indicated a fax was prepared for PAC-A to address the reddened area on R49's left foot. Review of a Problem Sheet to R49's physician, dated 7/5/13, at 11:00 a.m., included a description of the area on the (L) foot as noted above. There was no documentation or evidence to indicate the physician or PAC-A responded to this until 7/9/13, when PAC-A made a routine visit to the facility. Orders from PAC-A on 7/9/13, included, "Needs to be seen...Levaquin 500 mg [one by mouth] daily x 10 days. Dx [diagnosis]: Cellulitis...Clean ulcerated area with wound cleanser. Pat dry. Apply Repara Hydrocolloid to wound. Dx: Pressure ulcer L 2nd toe...Recheck ulcer and cellulitis on 7/11/13." A review of the Shower Day Worksheet, dated 7/9/13, indicated no skin issues. On 7/9/13, at 10:50 p.m. a progress note indicated, "Resident's sore on her left cheek on her bottom is 0.5 cm by 0.7 cm. Edges are red inside is a dark reddish color." A Problem Sheet addressed to PAC-A, on 7/14/13, at 1:35 p.m. included, "Please examine black spot on left	F 314		

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F 314	Continued From page 16	F 314		

buttocks. Any treatment?" A response from PAC-A on 7/15/13 indicated, "Change foam dressing on L buttocks if soiled. Recheck 7/18/13. Dx: Buttocks ulcer."

A progress note on 7/19/13, at 11:50 a.m. included "Diabetic foot check done this shift. Bilateral Feet are warm and of normal color. +1 pitting edema of the feet. Sore on resident's left 2nd toe is covered, dressing intact. Pea sized area of redness on the tip of resident's left great toe as well as on the resident's left 2nd toes (above sore) No redness otherwise noted or swelling around the area."

On 7/21/13, at 6:44 a.m. a progress note included, "1.5 x 2 cm. Stage II ulcer (Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough) on right shoulder. Red around edges. Cleansed and covered with Allyven dressing." On 7/22/13, at 7:00 a.m. a progress note indicated, "[R49] is starting to develop a red area on her right shoulder that has a brown center. Will have PA examine on rounds." A review of a Problem Sheet addressed to PAC-A, dated 7/22/13, at 7:00 a.m. indicated, R49 "is starting to develop a pressure ulcer on her R shoulder. Please examine and advise on treatment." PAC-A responded on 7/22/13, with orders including "Repara dressing applied. Ulcer stage 1-2. 3.5 cm diameter of erythema [redness]. 1.5 cm diameter grey ulcerated center. No depth to lesion. No drainage. Change dressing and recheck on Thursday 7/25/13." There was no re-assessment of the resident's risk for pressure ulcer development, despite the new development of pressure ulcer.

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F 314	Continued From page 17 A review of a Physician Visit form, dated 7/22/13, included orders from PAC-A indicating a specialist needed to evaluate R49's left 2nd toe due to "Bone exposed to air." Orders also included, "Wound culture. Dx: osteomyelitis." Antibiotics were ordered and the boot was removed from her left foot, with orders to discontinue the use of the boot until further notice. On 7/23/13, at 6:30 p.m. a progress note indicated ".75 cm dark scab on right buttocks. 3 cm red inflamed area around scab. Allyven dressing applied." There was no re-assessment of the resident's risk for pressure ulcer development, despite the new development of pressure ulcer. On 7/25/13, at 9:00 a.m. a progress note indicated R49 left the facility for a follow up orthopedic appointment "related to her open sore on her toe from the Cam boot." A progress note on 7/25/13, at 1:36 p.m., indicated "Resident returned from dr visit. Dr wrote "patient will be undergoing second toe amputation mon [Monday] July 29. She will be scheduled at an outpatient surgery center but will require a pre-op H&P [history and physical]. She may discontinue the boot as the ankle fracture looks stable and continues to heal. Keep toe covered with clean, dry dressing." A review of a progress note dated, 7/26/13, at 1:31 p.m., indicated R49's electrocardiogram (EKG) showed bradycardia (slow heart rate) and the surgery to amputate her toe would probably be postponed. A physician's progress record note on 7/29/13, included, "Cardiology was consulted...Surgery for toe amputation was cancelled [sic]." R49 was to have a follow up at	F 314		

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F 314	Continued From page 18 the Heart Clinic to clear her for surgery. A progress note, dated 7/26/13, at 9:00 p.m. included, "Nar [nurse aide] reports reddened [sic] area midback on left side, resident positioned with pillows to keep off of area." There was no re-assessment of the resident's risk for pressure ulcer development, despite the new development of pressure ulcer. On 7/30/13, at 8:40 a.m. a progress note titled, "Discharged," indicated R49 was picked up and transported to an appointment, and then would be returning to the facility where she resided prior to admission to this facility. During an interview on 11/21/13, at 3:58 p.m. registered nurse (RN)-A and licensed practical nurse (LPN)-A, both remembered caring for R49. LPN-A verified R49 had a boot on her left foot on admission and recalled there were no orders or directions as to how to care for her left foot or directions for use of the boot. When asked what interventions were put into place for R49, in regards to the boot and to prevent pressure ulcers such as the one that developed on her second toe, LPN-A was unable to locate that information in the electronic system. During an interview on 11/21/13, at 4:20 p.m. PAC-A reported she had no information about R49's left ankle fracture upon her admission to the facility and had requested R49's old medical records and orthopedic records from her ankle fracture when she saw her on 7/2/13. When asked about the pressure ulcer that was identified on 7/5/13, on R49's 2nd toe on her left foot, PAC-A stated she was not aware of the ulcer until	F 314		

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F 314	Continued From page 19 she saw R49 on 7/9/13, when she visited the facility. PAC-A verified, according to the fax, the charge nurse sent information regarding the area on the left foot and 2nd toe on 7/5/13, at 11:00 a.m. to R49's physician. There was no evidence that the physician responded to the fax or that the facility staff attempted to contact the physician when no response was received. PAC-A stated, "If this is what it looked like, it should have been handled a little more aggressively." During an interview on 11/21/13, at 4:43 p.m. director of nursing (DON) reported they had no orders upon admission regarding R49's boot on her left foot. When asked about the skin collection tool, dated 7/1/13, DON verified there was no documentation of any concerns on R49's feet or shoulders. DON stated she did not know what was meant by the description "vascular" that was documented on the Skin Collection Tool, noted on R49's left buttocks. DON stated, "apparently they saw something and they didn't know what to call it." When asked about R49's care plan, DON verified there were no interventions on the care plan to prevent further pressure ulcers, stating, "We have a turning and repositioning plan but I would expect to see that on the care plan." DON verified that pressure ulcers were triggered on the CAA, and stated, "It didn't get carried to the care plan." When asked about the fax that was sent to R49's physician on 7/5/13, at 11:00 a.m. that noted the concern on R49's left foot and toe, and there was no documentation of a response from the physician or follow up from the staff, DON stated, "The order should have been addressed with more urgency." A request was made for a Care Plan policy and a	F 314		

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F 314	Continued From page 20 Pressure Ulcer policy. DON stated, "We don't have one."	F 314		
F 320 SS=D	483.25(f)(2) NO BEHAVIOR DIFFICULTIES UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern is unavoidable. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 resident (R69) reviewed for behaviors, was assessed and care planned to address inappropriate behaviors which include suicidal ideation's. Findings include: R69 was admitted to the facility on 8/5/13, and according to the physician orders of 10/7/13, R69 had a diagnosis which include depressive disorder. R69 was being seen by the licensed independent clinical social worker (LICSW) due to ongoing behavioral issues that impacted his quality of life, in addition to those residing at the facility. However, the LICSW's recommendations were not care planned or implemented, nor was the attending physician notified of concerns identified. An admission Minimum Data Set (MDS)	F 320	**Tag** F 320 SS=D- No Behavior Difficulties unless unavoidable **A.) Resident Focus:** Per directive of the closet care plan CNA's, Activities, Licensed Nurse, and/or Social Services will have 1:1 sessions with resident to discuss symptoms once a week until resident's symptoms are less frequent. Social Services will monitor task list weekly x4 and monthly x11 to assure compliance by staff. **B.) Corrective Action:** Social Services and/or Licensed Nurse will notify resident's Physician and LICSW of concerns identified. Social Services will make a note on the Point of Care homepage to make licensed staff aware of the new interventions. Social Services will audit both closet and Point of Care Care Plans and make changes according to intervention recommendations and/or symptoms. During the QAPI process Social Services will express concerns and request for recommendation from QAPI team on a quarterly basis. Social Services will communicate with family to discuss all interventions either by holding a Care Conference or by phone. The care plan will be reviewed during the residents quarterly.	

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F 320	Continued From page 21 completed on 8/12/13, indicated R69 had no communication barriers. He was considered to be cognitively intact but did have periods of inattentiveness. He did report on a daily basis, he felt no pleasure or interesting in doing things, feelings of depression, sleep disturbance and a change in his energy level. He also indicated he had thought he would be better off dead several days per week. The MDS indicated he had no signs or symptoms of psychosis and the only behavioral issue was his verbal aggression. The behavioral issues did not put the resident at risk but it did significantly interfere with his care, activities or social interactions. The assessment also noted his behavioral issues did significantly disrupt the care or living environment of other residents. He was generally cooperative with personal cares. The Care Area Assessment (CAA) completed on 8/12/13, identified cognitive loss/dementia, psychosocial well-being, mood and behavioral symptoms as actual problems for R69. The assessment indicated for all care areas that the resident will be cued and prompted by staff. Resident diagnosed with depression disorder. Resident will be redirected by staff when resident shows signs of inattention and disorganized thinking. Resident will be offered activities throughout day. The CAA lacked identification of the specific impact of the problem on the resident. R69 was seen by his personal physician on three occasions, 8/13/13, 9/3/13 and 10/7/13. The reports from his personal physician were reviewed and there was no mention of any concerns regarding resident's behavior, cognition, or mood.	F 320	**C.) Plan of Action:** Social Services will measure symptoms by using the BIMS and PHQ9 assessments as well monitor symptoms by adding it to the Point of Care for staff to chart during the 14 day, Quarterly, and Comprehensive assessments. Social Services and Licensed Nurse will update resident's LICSW and Physician if interventions were unsuccessful and request for a reevaluation Date of correction 12/19/13 Per phone conversation with DOH & Social worker on 1/6/14	

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F 320	Continued From page 22 R69 was seen for a diagnostic assessment by a consulting LICSW on 8/5/13. As a result of the assessment, recommendations were made for the resident to be seen by his personal physician as soon as possible to review his pain medication and for his personal physician to consider use of an antidepressant simultaneously to treat pain and mood. In addition, it was recommended the resident liked "BS'ing" even if not into [the] program and responded well when out in the public area socializing [with others] and it was important for the resident to staying meaningfully involved as during these times, the focus on pain diminished. She recommended for the resident's physician to decide to increase pain medication and to consider a pain clinic. She recommended the 15 minute safety checks were not needed but his room was to be secure and to work with him around the common goals of reducing his suffering (pain, etc.) and convey hope that he won't be alone and can improve. R69 was seen by the LICSW on 8/27/13, with no further recommendations. He was seen again on 9/5/13, with recommendation that occupational therapy evaluate the potential use of his motorized wheelchair, consultation with physician regarding a proposed plan to allow R69 to leave the facility for outings and to have discussion regarding the risks of R69 possibly having a beer with a friend and his checking in with staff. She also recommended that discussion of the resident possibly transitioning to assisted living setting as this might be an effective step toward independence and would likely improve his mood. The resident's care plan was established 8/23/13, and identified a problem area in which R69 made	F 320		

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F 320	Continued From page 23 verbal suicidal threats with no prior attempts. He had reported he had a gun at his home that he would use on himself. The goal was established to maintain his safety and to eliminate or reduce his suicidal tendencies. Staff were instructed to document a summary of each episode and to document a change in the resident's affect. They were also instructed to notify social services when the resident made any suicidal threats. There was no indication of an established plan which would be implemented if the resident became suicidal to keep the resident safe only to notify the social worker. The care plan lacked the recommendations from the LICSW. The goals of the care plan were not measurable and there was no evidence that monitoring of the problems areas had occurred. In addition, the care plan lacked specific interventions the nursing staff could implement for behavior management. The plan of care also did not specify a specific plan that would be implemented if the resident became suicidal or thoughts of self-harm. An interview with R69 on 11/19/13, at 10:06 a.m. revealed that he felt satisfied with the care he received from the facility. He reported he felt he was easy going until he got pushed and then he got mad. He reported he was unable to predict how he would respond. He admitted he did swear a lot and stated that was just the way he was. He indicated he had no intention of changing his language. He discussed an incident which occurred on the evening of his admission to the facility when he "lost his cool" as he was in so much pain he could not stand it any longer. He admitted he told the staff he was going to kill himself as he could not bear the pain any longer.	F 320		

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	245473	A. BUILDING _____ B. WING _____	11/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TERRACE HEALTH CARE CENTER	640 THIRD STREET GAYLORD, MN 55334

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F 320	Continued From page 24 He reported they "shipped me off to the psych unit" and all the "psych unit did was give me pain medication and sent me back here." During the interview the resident denied any thoughts of harming himself and denied any pain. The resident was interviewed a second time on 11/20/13, at 9:22 a.m. and reported the facility planned a meeting to discuss the possibility of transferring him to another facility in which he was not included in the meeting process. He reported that he was very angry about the potential transfer and indicated that he was told by the facility social worker he was offensive to other residents and staff. He again indicated that he was very angry and did not know what he had done that was offensive. As a result of this conversation with the social worker; he was going to refuse to leave his room. An interview with the facility social worker (SW) was completed on 11/20/13, at 11:37 a.m. she reported the resident has a lot of behaviors and used a lot of profanity in his conversations. She indicated the resident had a lot of arguments with staff and other residents and then will deny that anything happened. She also reported he had posted notes he had written which were very profane and offensive to other residents and would post them on his bedroom door. She indicated the resident was being seen by a consulting psychologist "a couple times a month" to attempt to address his behaviors. The social worker did not identify how the staff was made aware of the LICSW's recommendations or how those recommendations were to be added on the care plan. A review of the behavioral progress notes from	F 320		

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F 320	Continued From page 25 8/1/13 to 11/19/13 revealed progress notes which described his profane offensive language, his sexually inappropriate statements toward staff, episodes of eating food off other residents' plates, medical noncompliance, other residents' complaints regarding R69's behavior, an episode of consuming mouthwash and his angry statements towards administrative facility staff. There was no follow up to these notes to indicate if any interventions worked or if the social worker or LICSW was involved. There was also no indication in the medical record to identify suicide monitoring for R69. An interview with trained medication assistant (TMA)-A was completed on 11/18/13, at 7:15 p.m. She reported the resident reported having constant pain "everywhere." She also reported he did make sexually or inappropriate statements at times and she would either ignore these statements or tell him they were inappropriate. TMA-A was unaware of LICSW's recommendations for R69. An interview with the director of nurses (DON) was completed on 11/21/13, at 11:21 a.m. She reported sometimes the resident is very pleasant and at other times, he had behavioral issues. She reported she did not feel the resident was appropriately placed at the facility as he was so much younger than the other residents. She indicated the staff spend considerable amount of time trying to deal with his behaviors. DON as unaware of the LICSW's recommendations for R69. An interview with nursing assistant (NA)-F was completed on 11/21/13, at 1:35 p.m. She reported she was aware of R69's history of	F 320		

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F 320	Continued From page 26 making very offensive statements but he didn't do it when she worked with him. She reported if he made inappropriate statements, she would ignore it. She reported she felt he was appropriate with her as "it how you talk to him." NA-F was unaware of the LICSW's recommendations for R69. An interview with NA-G was completed on 11/21/13, at 1:37 p.m. She reported R69 would "moan and groan" in public which was offensive to some staff and residents. She also reported he would tell "off colored jokes." She reported she would attempt to redirect the resident and his conversation if this happened and then tell the nurse. NA-G was unaware of the LICSW's recommendations for R69. An interview with NA-H was completed on 11/21/13, at 1:40 p.m. She reported R69 had a history of joking with staff and residents. She indicated when he made inappropriate statements, she would generally tell him "that was inappropriate", which sometimes worked and sometimes it did not. NA-H was unaware of the LICSW's recommendations for R69. An interview was completed with R69 on 11/21/13, at 4:31 p.m. He reported the staff had a meeting on this date regarding possibly transferring him to another facility, which he was not present at. He indicated the Ombudsman and he thought his brother were in attendance. He reported he wanted to remain at the facility. He verbalized he was not involved in the development of his plan of care and he did not	F 320		

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F 320	Continued From page 27 know what his care plan indicated.	F 320	F 323 Corrective Actions:	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident specific fall interventions were implemented according to the physician order and therapy communication, for 1 of 3 residents (R46) reviewed for accidents. Findings include: R46 fell on 11/1/13, and sustained an injury of a fractured right fibula (a bone in the leg which extends from the knee to the ankle). The quarterly Minimun Data Set (MDS) dated 9/14/13, revealed R46 to have a Brief Interview for Mental Status (BIMS) score of 15, which indicated R46 to be cognitively intact. It also indicated R46 to require extensive assist of one staff for transfers. The Fall Scene Investigation Report dated 11/1/13, at 4:00 p.m. indicated no assistive device at the time of the fall, and R46 had not utilized	F 323	Residents Care plan was updated at the time of the survey visit when it was noted missing. This was done on 11/21/13, per MDS nurse. MDS nurse was educated per DON on updating the care plan with any changes from providers. To provide those changes to the staff on the closet care plan as well as report. The DON/ADON will audit provider changes that are in writing that the changes are then put in the care plan. Audits of charts will be completed weekly x 4 then monthly times 11; and be a part of the quarterly QAPI process. This has been corrected on 11/21/13.	

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F 323	Continued From page 28 footwear with a grip on the bottom. Physician's visit note dated 11/13/13, indicated " WBAT [weight bearing as tolerated] in boot with walker, may remove boot - only needed when ambulating, OT/PT [occupational therapy/physical therapy] for R [right] ankle strength / ROM [range of motion], follow up in three weeks. " Therapy communication dated 11/19/13, indicated for R46 to perform all transfers with EZ stand. Remind her to stand up tall. Please have Cam Boot [a boot to support the foot or ankle after injury] on for all transfers at this time. During an observation on 11/20/13, at 8:37 a.m. R46 was transferred off the toilet by nursing assistant (NA)-C, with the EZ stand. R46 was informed she would be raised up, however was not prompted to stand up straight. R46 was then placed in her recliner, visibly leaning to the right. Her Cam boot was not removed after being placed in the recliner. When interviewed on 11/20/13, at 8:45 a.m. NA-C indicated resident was recently changed to transfer with the EZ lift with assist of one staff, that they are always to have the boot on during transfers, leave it on during the day, and remove it at night. She stated she was not aware of any other special instructions. When interviewed on 11/20/13 at 12:30 p.m., registered nurse (RN)-B indicated after a fall, recommendations are placed on the Fall Scene Investigation Report which is sent to the director of nursing (DON), administrator, social worker, and the MDS nurse. She also indicated the MDS nurse is responsible for updating the care plan as	F 323		

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F 323	Continued From page 29	F 323		

well as the "closet" care plan which is kept in the resident's rooms.

When interviewed on 11/21/13, at 8:33 a.m., NA-D revealed the "closet" care plan indicated R46 was to be transferred with the EZ stand, but there was nothing noted on this about the Cam boot. She also verified this was last signed off as being updated 4/4/13. NA-D stated the boot is to be left on when in the chair after a transfer.

When interviewed on 11/21/13, at 9:32 a.m. RN-C indicated R46 is now using the EZ lift for transfers. Any changes from therapy are in the form of a therapy note, which the charge nurse puts in a progress note. She indicated the nursing assistants should be following this. She indicated the nursing assistant or charge nurse would update the "closet" care plan, which should be checked weekly. She verified it was last updated 4/4/13. She verified the boot should be noted on the "closet" care plan. RN-C stated she was not sure if anything was changed on the care plan after the fall on 11/1/13. She verified the care plan did not mention the Cam boot.

When interviewed on 11/21/13, at 10:50 a.m. physical therapist (PT)-A indicated R46 is to be transferring with the EZ stand and the Cam boot on. She revealed they only give recommendations, and do not write anything in the care plans.

When interviewed on 11/21/13, at 1:30 p.m. NA-E indicated R46 transfers with the EZ stand and wears the boot during transfers, but was not aware of anything further.

When interviewed on 11/21/13, at 2:30 p.m. the

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F 323	Continued From page 30 director of nursing (DON) verified the care plan made no mention of the Cam boot. She indicated the "closet " care plan is a tool, and not a part of the care plan. She also indicated it would be her expectation the care plans be up to date. Facility policy titled Fall Risk Assessment, reviewed 5/12, noted, " If at any time the total points on the assessment form are 10 or above the MDS Coordinator will implement fall prevention protocol and place approaches in the plan of care. "	F 323		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (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	F 441		

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F 441	Continued From page 31 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 equipment used for multiple residents was cleaned/disinfected appropriately between uses for 1 of 1 resident (R15) observed to be transferred with mechanical lift, and for 1 of 1 resident (R69) observed to have a blood glucose check. This had the potential to affect 10 of 37 residents, who use the mechanical standing lift, and 6 of 6 residents who used the glucometer. Findings include: Staff did not follow infection control principles to prevent cross contamination while using a standing mechanical lift. R15 was observed on 11/18/13, at 7:30 p.m. nursing assistant (NA)-A assisted R15 with a standing mechanical lift to the bathroom. NA-A adjusted the standing mechanical lift in front of R15 and left the back sling on R15 and attached to the standing mechanical lift. NA-A stated that	F 441	F 441 Corrective Actions: Resident 15 Per Policy and Procedure staff will clean/disinfect appropriately between resident uses of the mechanical lift. F 441 System Corrective Actions: All staff was educated on the Policy and Procedure of cleaning/disinfecting appropriately the mechanical lift device (Attachment F)between resident uses. This will be the responsibility of the DON; all education will be completed by the date of 12/19/13. Staff will sign that the policy was reviewed with them. DON will have the responsibility of auditing the staff using the mechanical lifts and cleaning between residents. New staff orientation will include cleaning/disinfecting mechanical lifts. (Attachment G)Audits completed will be part of the quarterly QAPI process.	

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

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F 441	Continued From page 32 R15 would be left alone in the bathroom and NA-A would return in approximately 10 minutes to check on R15. NA-A returned at 7:36 p.m. to R15's bathroom to assist with toileting. NA-A put gloves on and used the control on the standing mechanical lift to raise R15 off the toilet. NA-A then cleaned R15's perineal area. NA-A pulled up R15's pants and adjusted them. NA-A did not remove the soiled gloves and moved R15 and the standing mechanical lift from the bathroom to the recliner and lowered R15 into the recliner. NA-A unhooked the back sling from around R15 and the standing mechanical lift and put it on the lift. While the soiled gloves were still on, NA-A gave the call light to R15. NA-A then assisted the roommate and moved their wheelchair in the room with the soiled gloves still on. NA-A tied the bag of garbage and removed it from the bathroom to the soiled container in the hallway. NA-A then removed the soiled gloves and placed them in the soiled container in the hallway. At 7:45 p.m. NA-A washed and dried his hands and went to do another task. The soiled standing mechanical lift remained in the hallway outside of R15's room. An interview on 11/18/13, at 7:46 p.m. with NA-A revealed gloves should be changed after every task. NA-A confirmed the gloves were not changed throughout assisting R15 and touching the roommate's wheelchair. An interview on 11/18/13, at 9:55 a.m. with the director of nurses (DON) indicated that gloves should be changed after cleaning a resident's perineal area and hands should be washed or sanitized. The DON confirmed that the standing mechanical lift should be cleaned after each residents' use. The facility did not follow infection control	F 441	F441 Resident Corrective Action: Resident 69 Staff will clean/disinfect appropriately the glucometer machine between resident uses. F441 System Corrective Action: All staff was educated on the Policy and Procedure of cleaning/disinfecting appropriately the glucometer device between resident uses. (Attachment H) This will be the responsibility of the DON; all education will be completed by the date of 12/19/13. Staff will sign that the policy was reviewed with them. DON will have the responsibility of auditing the staff using the glucometer and cleaning between residents. New staff orientation will include cleaning/disinfecting glucometer. (Attachment B) Audits completed will be part of the quarterly QAPI process.	

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F 441	Continued From page 33 practices to prevent cross contamination for disinfecting a glucometer. On 11/19/13 at 11:00 a.m., licensed practical nurse (LPN)-F was observed to test R69's blood sugar with the community glucometer by the nurses' station. The glucometer was placed directly on the medication cart, the glucometer strip placed into the machine and a drip of resident's blood was placed on the strip. After the machine calculated the blood sugar result, LPN-F was observed to place the glucometer into a plastic bin and put it in the top drawer of the medication cart. LPN-F was not observed to disinfect the machine. LPN-F was interviewed and reported she had briefly wiped the glucometer with an alcohol pad prior to putting it away in the cart. She verified she had not wiped the medication cart prior or after she used the machine to test the resident's blood sugar. An interview with the director of nurses (DON) was completed on 11/20/13, at 8:23 a.m. She reported staff were to disinfect the glucometer between use using a germicidal cleaner such as Super Sani Wipe, which was available in all medication carts. She also verified the top of the medication cart should have been cleaned with the same product after the blood sugar testing was done or a barrier on top of the medication cart should have been used. The facility's policy Glucometer Cleaning, revised 6/12, directed staff to sanitize glucometer with an EPA-registered antimicrobial cleaner (that is effective against Mycobacterium tuberculosis, HIV, Hepatitis B and Hepatitis C). Staff are to	F 441		

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F 441	Continued From page 34 cleanse the monitor with the approved wipes for 30 seconds and allow the monitor to air dry three minutes between used.	F 441		

Oak Terrace Health Care Center of Gaylord, L.L.C.

Department: Nursing
Effective Date: 04/06; 7/12 VH; 12/13 VH
Reviewed/Revised Dates:
Subject: Turning & Repositioning
Manual Section:
Issued By: Nursing Administration
Primary Responsibility: Licensed Nurses

Attachment A

Policy: It is the policy of the Oak Terrace Health Care Center of Gaylord, L.L. C. that all residents will receive appropriate treatment to prevent pressure sores and skin breakdown through appropriate turning and repositioning programs.

Purpose: To ensure maintenance of intact skin and the prevention of pressure sores.

Procedure:

1. All residents will be repositioned as indicated on their care plans. Turning intervals will be based on individual skin assessments including a visual inspection of the skin via tissue tolerance testing as well as other potential complicating factors.
2. Repositioning intervals will be added to the NA/R group lists as well as the care plan.
3. Report to your next shift or charge nurse when you last repositioned your residents at the end of your work shift.

Medical Director Signature_____Date_____

Oak Terrace Licensed Staff Orientation Checklist

Employee _____ Start Date _____

Attachment B

SKILL SET	Reviewed
Direct daily cares & functions to supervisory staff under current regulations & guidelines of LTC including monitoring, coordination and delegation of duties to NAR's, aides and support staff	
Ensure all nursing staff under your supervision are in compliance with policies and procedures	
Knows location of facilities policies & procedures manuals	
Utilizes 24 hour report to communicate changes in condition to staff-delivers report at end of shift	
Reports changes in condition to physician and responsible party	
Understands LTC survey process and where to locate survey book	
Understands discharge planning worksheet responsibilities	
Understands admission, transfer, discharge and death paperwork & responsibilities	
Understands Accident/Incident reporting	
Understands daily census report (by elevator)-actual hours worked to be recorded	
Comprehends charting & documentation: IDT notes & monthly charting forms, vital signs	
Ensures accuracy of medication administration, including feeding tube skills, oral meds & insulin	
Understands CoaguChek INR Machine	
Glucometer procedure & machine operation and cleaning	
Performs Narcotic counts	
Performs medication disposal & ordering for appropriate pharmacy of choice	
Understands comprehensive care planning	
Understands tissue tolerance testing	
Follows wounds documentation and wound protocol sheet	
Understands 72 hour bowel & bladder sheets	
Understands perineal inspection	
Follows bladder scanner usage	
Comprehends indwelling catheter care & documentation	
Understands lab monitoring-routine and on time lab orders	
Comprehends grievance filing and the department chain of command	
Peak shaving-generator switch over	
Understands the ordering of supplies for CSR after hours	
Properly transcribes physician orders, including transfer sheets, telephone & faxed orders	
Diet slip ordering	
Performs effective Communication with Therapy department on current physician orders	
Performs change of status form completion for the appropriate changes	
Understands how to initiate temporary care plan and put in residents closet care plan	
ADMINISTRATIVE	
Basic telephone training-answering and transferring calls	
Appointment Slips and scheduling	
Doctors rounds and physician visit scheduling	
Understands severe weather policy & tornado safety	
Comprehends fire panel and fire procedure	

Above all, maintains a warm & caring environment for residents, families and other staff

I certify that I have completed training regarding the above duties and understand the facilities policies and procedures. I acknowledge that this may not be an exhaustive list of job responsiblities and I should contact my supervisor with additional training needs.

_____ _____

EMPLOYEE SIGNATURE DATE

_____ _____

SUPERVISOR SUPERVISOR SIGNATURE

Bathing:
Bath Day: _____
- ❑ Tub
- ❑ Shower
- ❑ Assistance
- ❑ Special Soap/Shampoo
- ❑ Beauty Shop

Special Instructions:

Attachment C

Dressing:
- ❑ Independent
- ❑ Assistance Needed

Type: _____
- ❑ Ted Socks
- ❑ Ace wraps to legs
- ❑ Geri-socks/Skin protectors

Grooming:
- ❑ Independent
- ❑ Assistance Needed

Type: _____
- ❑ Eye Glasses
- ❑ Hearing Aide(s)
- ❑ Dentures

upper lower partial
_____ in _____ out at bedtime
- ❑ Nail Care

Initial Nurse Signature:

_____

Date:

Mobility:

	Self	SBA	1:1	2:1
Bed	❑	❑	❑	❑
Transfer	❑	❑	❑	❑

- ❑ Walking
- ❑ Transfer/Gait Belt
- ❑ Gripper Socks
- ❑ Walker
- ❑ Cane
- ❑ Wheelchair
- ❑ Mechanical Lift Assist 1-2

Positioning Plan:

Special Skin Care Intervention:

Toileting:
- ❑ Commode
- ❑ Urinal
- ❑ Toilet
- ❑ Catheter
- ❑ Bedpan

Toilet Schedule

Product Use:

Type: _____

Size: _____

Day/PM _____

Night: _____

Nutrition/Eating:

Diet: _____
- ❑ Choking Precautions
- ❑ Food Allergies
- ❑ Supplements/Snacks
- ❑ Eating/Dining

Assistance: _____

Restorative Program:

	RNA	NAR
ROM	❑	❑
Ambulation	❑	❑
Dining	❑	❑
Exercise	❑	❑
ADL's	❑	❑
Splints	❑	❑
Walk-to-dine	❑	❑

Special Instructions:

Therapy Services:

PT OT Speech

Fall Risks: (safety devices)
- ❑ Magnetic monitor in Chair
- ❑ Magnetic monitor in Bed
- ❑ Sensory monitor in Chair
- ❑ Sensory monitor in Bed
- ❑ Lap Buddy
- ❑ Fall EZ mat

Other: _____

Mental Status:
- ❑ Alert & Oriented
- ❑ Forgetful/Needs Reminders
- ❑ Confused/Cognitively Impaired

Targeted Behaviors:
1.
2.
3.

Interventions:
1.
2.
3.

Special Nursing Instructions:

Code Status:

Affix Resident Name Label Here

Family Information/Emergency Contacts: _____

_____

_____

Social Information: _____

_____

_____

Likes: _____ Dislikes: _____

Special Instructions

Days: _____

Evenings: _____

Nights: _____

WEEKLY REVIEW/REVISION:

Date	NAR Initials	Nurse Initials	Date	NAR Initials	Nurse Initials	Date	NAR Initials	Nurse Initials	Date	NAR Initials	Nurse Initials	Date	NAR Initials	Nurse Initials

Oak Terrace Health Care Center of Gaylord, L.L.C.

Department: Nursing
Effective Date: 04/06; 7/12 VH; 12/13 VH
Reviewed/Revised Dates:
Subject: Turning & Repositioning
Manual Section:
Issued By: Nursing Administration
Primary Responsibility: Licensed Nurses

Attachment D

Policy: It is the policy of the Oak Terrace Health Care Center of Gaylord, L.L. C. that all residents will receive appropriate treatment to prevent pressure sores and skin breakdown through appropriate turning and repositioning programs.

Purpose: To ensure maintenance of intact skin and the prevention of pressure sores.

Procedure:

1. All residents will be repositioned as indicated on their care plans. Turning intervals will be based on individual skin assessments including a visual inspection of the skin via tissue tolerance testing as well as other potential complicating factors.
2. Repositioning intervals will be added to the NA/R group lists as well as the care plan.
3. Report to your next shift or charge nurse when you last repositioned your residents at the end of your work shift.
4. Staff when they noticed a change in skin condition will then notify charge nurse.

Medical Director Signature_____Date_____

Oak Terrace Health Care Center of Gaylord, L.L. C.

Attachment E

Department: Nursing
Effective Date: 4/2006
Reviewed/Revised Dates: 11/07 HK; 4/08 HK; 01/10 HK;6/12 VH
Subject: **Change in Resident's Condition or Status**
Manual Section:
Issued By: Nursing Administration
Primary Responsibility: Licensed Nurses

Policy: Oak Terrace Health Care Center of Gaylord, L. L. C. shall promptly notify the resident, his or her attending physician, and representative of changes in the resident's condition and /or status.

Purpose: To ensure the physician is notified of the resident's changing condition so prompt interventions are initiated by the physician's direction to include a significant treatment alteration, or transfer to a hospital.

Procedure: 1. the nurse supervisor will notify the resident's attending physician when:

a. the resident is involved in any accident or incident that results in an injury including Injuries of an unknown source;
b. There is significant change in the resident's physical, mental or psychological Status;
c. There is a need to alter the resident's treatment significantly (such as in the case of critical lab work)
d. The resident repeatedly refuses treatment or medication (i.e. 2 or more consecutive times).
e. The resident is discharged without proper medical authority; and/or
f. Deemed necessary or appropriate in the best interest of the resident
g. The resident is involved in any type of fall incident

2. Unless otherwise instructed by the resident, the nurse supervisor will notify the resident's Next-of-kin or representative when:
    a. The resident is involved in any accident or incident that results in an injury including injuries of an unknown source;
    b. There is significant change in the resident's physical, mental, or psychological status;
    c. There is need to alter the resident's room assignment;
    d. A decision has been made to discharge the resident from the facility; an/or
    e. It is necessary to transfer the resident to the hospital
    f. The resident is involved in any type of fall incident
    g. There is a need to alter the resident's treatment significantly (such as in the case of critical lab work or need to stop/start a medication)

3. Except in medical emergencies, notifications will be made within 24 hours of a change occurring in the resident's condition or status.
4. Critical lab work shall be called immediately to a physician with direct conversation occurring between licensed staff and the provider. ***Critical labs may be faxed only if a phone call is made to the provider also.***
5. Regardless of the resident's mental pr physical condition, nursing services will inform the resident of any changes in his/her medical care or nursing treatments.

The charge nurse will record in the resident's medical record any changes in the resident's medical condition or status

Attachment F

Oak Terrace Health Care Center of Gaylord, L.L.C.

Department: Nursing

Effective Date: 11/14/2011; revised; 6/12 VH

Subject: **Mechanical lift/EZ stand**

Manual/Section: Administration/Infection Control

Issued by: Nursing

Primary Responsibility: Licensed nurses, TMA's, CAN's, NAR's

Purpose: To provide guidelines for sanitizing Mechanical lifts/EZ Stands:

Policy: The EZ stand/EZ lift will be sanitized per manufacture guidelines as well as industry standards.
Mechanical lifts/stands should be disinfected with an EPA-registered antimicrobial that is effective against *Mycobacterium tuberculosis*, Human HIV-1 and the Hepatitis B and C viruses.3 you can find the EPA's list of approved products at http://www.epa.gov/oppad001/list_d_hepatitisbhiv.

Procedure:
1. After each resident use cleanse the stand with the approved wipes found in the med carts for 30 seconds.
2. Allow the stand to air dry three minutes between uses.

Employees are educated on orientation and annually.

Attachment G

NAR ORIENTATION & COMPETENCY CHECKLIST

TOUR OF NURSING DEPARTMENT

		Demo (Initial & date)	Return Demo (Initial & date)
1. Reporting to duty:			
	Uniform, shoes, name tag	_____	_____
	Personal Grooming (hair, nails, etc)	_____	_____
	Daily schedule & assignment	_____	_____
2. Nursing Stations:			
	Birch/ Report Rooms	_____	_____
	Communication Book/Boards	_____	_____
	NAR assignments	_____	_____
	Policy & Procedure Manuals	_____	_____
	Safety Manual	_____	_____
	Telephone System		
	Answering the phone	_____	_____
	Transferring a call	_____	_____
	Overhead paging	_____	_____
	Resident Telephone Line	_____	_____
	Call System Pagers		
	Resident Call Light/placement/reset	_____	_____
	Resident Bathroom Light	_____	_____
	Exit Door Light	_____	_____
	Wander guard Alarm	_____	_____
	Chart Locations & NAR responsibility to:		
	Resident Medical Record	_____	_____
	72 Hour B & B	_____	_____
	Behavior Charting	_____	_____
	Point Click Care/MDS Charting	_____	_____
3. **Resident Rooms:**	General Set-Up	_____	_____
	Heater/ Air Conditioner Operation	_____	_____
	Bed(s) Operation	_____	_____
4. **Linen Storage**		_____	_____
5. Utility Rooms			
	Oak Lane Tub Room	_____	_____
	Personal Care Items	_____	_____
	Linen Cart	_____	_____
	Clean Utensils (bedpans, urinals)	_____	_____
	Birch Lane Linen Closet		
	Blanket Warmer	_____	_____
	Bed spreads & ambulance linen	_____	_____
	Personal Care Items	_____	_____
	Pine Soiled Utility Room	_____	_____
	Oak Lane	_____	_____
	Laundry Storage	_____	_____
	Birch Soiled Utility Room	_____	_____
	Soiled Utensil process	_____	_____
	Oxygen Storage Room	_____	_____
6. Communication:			
	Listening to report	_____	_____
	Observations to report to the nurse	_____	_____
	End of shift report	_____	_____
	Confidentiality among team members	_____	_____
	Key components of a team approach	_____	_____

	Demo (Initial & date)	Return Demo (Initial & date)
7. Safety, Employee Right to Know & Infection Control:		
Proper hand washing techniques	_____	_____
Hand sanitizer application	_____	_____
Proper use of personal protective equipment (Gloves, mask, goggles, gown)	_____	_____
Proper handling of clean linen	_____	_____
Proper handling of soiled linen	_____	_____
Utensil sanitation procedure	_____	_____
Location and importance of bedpan & urinal covers	_____	_____
Disinfecting items after each resident care:		
Commodes, Tub – Oak Lane, Tub – Birch Lane	_____	_____
Fingernail/ toenail clippers, Shower Chairs	_____	_____
Locking up chemicals when not in use	_____	_____
8. Personal Care of Residents		
Closet Care Plan & NAR's responsibility to it	_____	_____
Making an occupied & unoccupied bed	_____	_____
Giving a bed bath	_____	_____
Giving a shower	_____	_____
Giving a bath	_____	_____
Hair care/ Beauty shop schedule	_____	_____
Shaving male & female residents	_____	_____
Disinfecting personal shavers	_____	_____
Fingernail & toenail care (nurse does for diabetics)	_____	_____
Oral care	_____	_____
Denture care	_____	_____
Eyeglass care	_____	_____
Hearing aid care	_____	_____
Assisting a resident with dressing	_____	_____
Assisting a resident with undressing	_____	_____
Skin care		
Back rub	_____	_____
Applying lotion	_____	_____
Protective sleeves	_____	_____
Turning & Repositioning	_____	_____
Keeping resident off pressure points	_____	_____
Reporting red, bruised, open areas or skin tears	_____	_____
Communicating with residents with speech impairments	_____	_____
9. Elimination		
Factors interfering with regular elimination	_____	_____
Care planned toileting schedules	_____	_____
Toileting methods:		
Bathroom toilet	_____	_____
Commode (BSC)	_____	_____
Bedpan	_____	_____
Urinal	_____	_____
Indwelling (Foley) and supra pubic catheters:		
Emptying of	_____	_____
recording output	_____	_____
Positioning of tubing	_____	_____
In wheelchair	_____	_____

	Demo (Initial & date)	Return Demo (Initial & date)
In bed	_____	_____
Leg bag application & disinfection	_____	_____
Changing a catheter bag	_____	_____
Colostomy Care	_____	_____
Reporting / Recording BM'S	_____	_____
Incontinent Residents		
Pad application / disposal	_____	_____
Bowel / Bladder Assessment Retraining	_____	_____
Use of B & B forms	_____	_____
Record keeping of products used	_____	_____
Perineal care for incontinence	_____	_____
10. Activity / Mobility Of Residents		
Policy for transferring residents'	_____	_____
Use of transfer belt	_____	_____
Stand by assist (SBA)	_____	_____
1:1 Assist	_____	_____
2:1 Assist	_____	_____
EZ Stand	_____	_____
EZ Lift (always needs 2 people)		
Cleaning stand before each resident use	_____	_____
Positioning		
In Bed	_____	_____
In chair or wheelchair	_____	_____
Use of wheelchair brakes	_____	_____
Use of overhead trapeze	_____	_____
Positioning devices & alarms		
TABS monitor	_____	_____
Wander Guard	_____	_____
Walking schedule	_____	_____
Documentation	_____	_____
Range of Motion:		
Passive	_____	_____
Active	_____	_____
11. Food/Fluid Intake		
Meal time schedule	_____	_____
Seating arrangement	_____	_____
Preparing resident for a meal	_____	_____
Cueing &/or feeding a resident	_____	_____
Special dietary needs (pureed, ground, thickened, etc)	_____	_____
Recording food/fluid intake	_____	_____
Diabetic/healthy snacks	_____	_____
Water pitchers	_____	_____
Special Procedures		
Measure & record height	_____	_____
Weight:		
Use of scale	_____	_____
Monthly & special weights	_____	_____
Ambulatory resident	_____	_____
Wheelchair bound resident	_____	_____
TED stockings:		
Application & removal	_____	_____
Washing of	_____	_____
Taking Vital Signs	_____	_____

	Demo (Initial & date)	Return Demo (Initial & date)
Recording Vital Signs	_____	_____
Use of Oxygen:		
Location of supplies	_____	_____
Care of concentrator	_____	_____
Care of tanks	_____	_____
Caring for a dying resident, Comfort measures		
Mouth care	_____	_____
Skin care	_____	_____
Grooming	_____	_____
Turning/Repositioning	_____	_____
12. Advanced Directives/ Health care decisions/ CPR:		
Location in chart	_____	_____
Meaning of Green Dot	_____	_____
Meaning of Peach Dot	_____	_____
13. **Resident Rights**	_____	_____
14. Informational Bulletin Boards:		
By Nursing Home Elevator	_____	_____
Official Administration BB	_____	_____
Employee news	_____	_____
Break room board	_____	_____

I have demonstrated to the new employee and have observed demonstrated competency in the signed off areas.

NAR Mentor's Initials	NAR Mentor's Signature	New Employee Signature	Date

Attachment H

Oak Terrace Health Care Center of Gaylord, L.L.C.

Department: Nursing

Effective Date: 11/14/2011; revised; 6/12 VH

Subject: **Glucometer Cleaning**

Manual/Section: Administration/Infection Control

Issued by: Nursing

Primary Responsibility: Licensed nurses and TMA's

Purpose: To provide guidelines for sanitizing glucometer:

Policy: The glucometer will be sanitized per manufacture guidelines as well as industry standards.
Blood glucose meters should be disinfected with an EPA-registered antimicrobial that is effective against *Mycobacterium tuberculosis*, Human HIV-1 and the Hepatitis B and C viruses.3 you can find the EPA's list of approved products at http://www.epa.gov/oppad001/list_d_hepatitisbhiv.

Procedure:
1. After each resident use cleanse the monitor with the approved wipes found in the med carts for 30 seconds.
2. Allow the monitor to air dry three minutes between uses.

Employees are educated on orientation and annually. Omnicare nurse consultant monitors compliance with each visit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245473	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/22/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TERRACE HEALTH CARE CENTER	**640 THIRD STREET** **GAYLORD, MN 55334**

(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	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on November 22, 2013. At the time of this survey, Building 01 of Oak Terrace Health Care Center was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. Oak Terrace Health Care Center was constructed as follows: Building 01 - The original building was constructed in 1974, it is one-story, has a full basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction; Building 02 - In 2008 a Resident Room addition was constructed, it is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction. Building 01 was surveyed at NFPA 101 (2000) Chapter 19 Existing Health Care Occupancies. Building 02 was surveyed at NFPA 101 (2000) Chapter 18 New Health Care Occupancies. Two (2) CMS Form 2786R booklets were completed. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 48 beds and had a census of 38 at time of the survey.	K 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245473	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/22/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TERRACE HEALTH CARE CENTER	**640 THIRD STREET** **GAYLORD, MN 55334**

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245473	A. BUILDING **02 - 2008 ADDITION** B. WING _____	**11/22/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TERRACE HEALTH CARE CENTER	**640 THIRD STREET** **GAYLORD, MN 55334**

(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	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on November 22, 2013. At the time of this survey, Building 02 of Oak Terrace Health Care Center was found to be 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 18 New Health Care Occupancies. Oak Terrace Health Care Center was constructed as follows: Building 01 - The original building was constructed in 1974, it is one-story, has a full basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction; Building 02 - In 2008 a Resident Room addition was constructed, it is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction. Building 01 was surveyed at NFPA 101 (2000) Chapter 19 Existing Health Care Occupancies. Building 02 was surveyed at NFPA 101 (2000) Chapter 18 New Health Care Occupancies. Two (2) CMS Form 2786R booklets were completed. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 48 beds and had a census of 38 at time of the survey.	K 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245473	A. BUILDING **02 - 2008 ADDITION** B. WING _____	**11/22/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TERRACE HEALTH CARE CENTER	**640 THIRD STREET** **GAYLORD, MN 55334**

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