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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: P80P

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00353

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245238**

2.STATE VENDOR OR MEDICAID NO.
(L2) **739745302**

3. NAME AND ADDRESS OF FACILITY
(L3) **MAHNOMEN HEALTH CENTER**
(L4) **414 WEST JEFFERSON AVENUE, PO BOX 396**
(L5) **MAHNOMEN, MN** (L6) **56557**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/19/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **42** (L18)

13.Total Certified Beds **42** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	42			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Supervisor 03/19/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 03/19/2015 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(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
08/04/1981
(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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5238

Electronically Delivered: March 19, 2015

Ms. Susan Klassen, Administrator
Mahnomen Health Center
414 West Jefferson Avenue
PO Box 396
Mahnomen, Minnesota 56557

Dear Ms. Klassen:

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 March 11, 2015 the above facility is certified for or recommended for:

42 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 42 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 feel free to call me with any questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: March 19, 2015

Ms. Susan Klassen, Administrator
Mahnomen Health Center
414 West Jefferson Avenue
PO Box 396
Mahnomen, Minnesota 56557

RE: Project Number S5238025

Dear Ms. Klassen:

On February 24, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 5, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On March 19, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 5, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 11, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 5, 2015, effective March 11, 2015 and therefore remedies outlined in our letter to you dated February 24, 2015, will not be imposed.

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

Please feel free to call me with any questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

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
245238	A. Building B. Wing	3/19/2015

Name of Facility	Street Address, City, State, Zip Code
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

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 **F0167** Reg. # **483.10(g)(1)** LSC	Correction Completed **02/05/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **02/06/2015**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **02/05/2015**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **02/12/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **02/12/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **03/11/2015**
ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **02/05/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/AK	03/19/2015	18623	03/19/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/5/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

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(L3) **MAHNOMEN HEALTH CENTER**
(L4) **414 WEST JEFFERSON AVENUE, PO BOX 396**
(L5) **MAHNOMEN, MN** (L6) **56557**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/05/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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To (b) :

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Compliance Based On:
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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
	42			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Magdalene, Jares, HFE NEII 03/17/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 03/19/2015 (L20)

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

19. DETERMINATION OF ELIGIBILITY
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____ 2. Facility is not Eligible
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3. Both of the Above :
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08/04/1981
(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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
February 24, 2015

Ms. Susan Klassen, Administrator
Mahnomen Health Center
414 West Jefferson Avenue, PO Box 396
Mahnomen, Minnesota 56557

RE: Project Number S5238025

Dear . Klassen:

On February 5, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gloria Derfus, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: Gloria.derfus@state.mn.us

Phone: (651) 201-3792
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 17, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 17, 2015 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 5, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 5, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

5238s15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	02/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to post prior survey results. This had the potential to affect families, staff, visitors and all 26 residents residing in the facility. Findings include:	F 167	Survey results were posted on 2/5/15. Last survey and plan of correction publically posted. Staff educated 2/24/15. QI monitoring for public posting. By 3/30/15, survey results will be permanetly attached to the wall, yet readily accessable to residents and the public.	2/5/15

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

Electronically Signed | 03/05/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	02/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(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 167	Continued From page 1 During the initial facility tour on 2/2/15, at 4:37 p.m. prior survey results were not posted. When asked, the Chief Executive Officer (CEO) stated survey results should be on the table near the nurse's station in a white book. CEO could not find the book and stated, "first time in 12 years it's not here." At 4:40 p.m. interim director of nursing (IDON) indicated having no idea where the survey results could be and did not think that anyone had taken the book to review. The IDON thought that it might have been missing since last year and stated, "we didn't reprint or ask for another copy."	F 167		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 329		2/6/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	02/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(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 329	Continued From page 2 drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to consistently measure heart rate (pulse) and blood pressure as ordered by the physician to monitor the effectiveness of a blood pressure lowering medication for 1 of 3 residents (R7). In addition, the facility failed to ensure 4 of 5 residents (R7, R2, R12, R35), reviewed for unnecessary medications, who took antidepressants and anti-anxiety medications had adequate monitoring. Findings include: The facility did not monitor and obtain the needed pulse and blood pressure to ascertain if the medication was effective or not effective for R7. R7's Physician Order Report signed and dated 1/13/15, revealed R7 had the following orders for diagnosis of Atrial Fibrillation: Amiodarone 100 milligrams (mg) hold if systolic blood pressure (SBP) was less than 100 and Lopressor 12.5 mg Hold if SBP was less than 100 and pulse rate (PR) less than 60. R7's care plan dated 7/19/11, identified R7 had a diagnosis of hypertension and had prescribed antihypertensive medications daily. The care plan directed staff to give anti-hypertensive medications as ordered, monitor for increased heart rate, effectiveness and to obtain blood	F 329	R7's perameters were discontinued due to MD's consideration for stable v.s on 2-12-15. Med passing staff educated on 2/6/15 to continue V.S parameters for medication until MD orders them D/C'd. Staff inservice on 2/24/15 on process. Plan added to existing Medication Administration policy and Antipsychotic Medication Policy amended. QI to monitor relation to parameters to EMar, with goal of 100% compliance to be reported to QI comm by Consulting Pharamacist. Pharmacist provided staff education on 2/12/15, non-pharm interventions to try before giving an antipsych medication, documenting the medication given if needed, outcome of the medication, proper documentation, dose reduction as an effort to reduce antipsyc meds. QI of nursing and Consulting Pharmacist to monitor unnecessary psych meds, reported to QI committe meeting with goal of 100% compliance. Side effects of antipsych,depressants and anxiety meds. Inservice completed by Consulting Pharmacist on 2/12/15 of side effects to watch for, document, report and med manage. List of meds' side effects placed on all medication carts. Staff	

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F 329	Continued From page 3 pressure readings under the same conditions each time. Medication Administration Records (MAR's) from September 2014, through February 2015, lacked documentation that blood pressures or pulse readings had been done prior to medication administration. R7 was observed on 2/4/15 between 7:21 a.m. and 2:00 p.m. During this time, upon rising from bed, R7 ate breakfast in the dining room, attended activities in the television lounge and was assisted to the bathroom by NA-A. R7 was noted to doze off and on during the morning activities. At 2:00 p.m. R7 was observed lying in bed with eyes covered with a blanket. At 2:14 p.m. R7 was observed with eyes open and started to rub eyes. Interview with R7 at this time when asked if R7 was tired stated, "am always tired and sleepy all the time." On 2/4/15, at 8:43 a.m. licensed practical nurse (LPN)-A was interviewed and indicated she had already administered R7's medications. When asked what R7's blood pressure and pulse readings had been prior to administering medications LPN-A explained that R7's readings for blood pressure and pulse had been stable and that the vital signs were only done once a month and had not been done this morning. On 2/5/15, at 9:00 a.m. the interim director of nursing (IDON) verified R7's orders had directions for checking the blood pressure and pulse and acknowledged the vital signs were supposed to be checked prior to medication administration to assure they were within range.	F 329	meeting held to inform all staff of side effects to meds and reporting process to nursing 2/24/15. Medication Administration and Antipsychotic Medication Policies amended. QI monitoring will be conducted by nursing and Cunsulting Pharmacist and reported at QI committee meeting for 100% compliance.	

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F 329	Continued From page 4 IDON verified that blood pressure and pulse had not been taken before administration of medications since September 2014. R7's Physician Order Report signed and dated 1/13/15, also revealed R7 had the following orders: Zoloft 100 mg once daily for depression and Lorazepam (Ativan) 0.5 mg once a day as needed (PRN) for anxiety. R7's quarterly, annual, interdisciplinary notes dated 6/1/14 through 2/5/15, lacked evidence of documentation for monitoring of side effects for Zoloft and lorazepam R7 received. R7's Psychotropic drug use Care Area Assessment (CAA) dated 4/3/14, identified R7 used Zoloft (antidepressant) and Ativan (lorazepam-anti-anxiety medication) as needed (PRN) and directed staff to use non-formulary interventions such as distraction, activities to distract R7 when complaining of eye problems prior to using Ativan. Psychotropic medication use care plan dated 7/19/11, identified R7 was at risk for side effects and/or adverse reactions due to daily use of antidepressant medication and use of as needed antianxiety medication. The care plan directed staff to administer medications as ordered, monitor and document side effects and effectiveness. Review of the MAR indicated R7 had received lorazepam, as needed dose, on 9/29/14, 1/29/15, and 1/31/15, and no non-pharmacological interventions prior to administering medication and effectiveness had been documented on 1/29/15, and 1/31/15. On 2/5/15, at 9:00 a.m. the interim director of	F 329		

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nursing (IDON) , verified side effects monitoring for Zoloft and lorazepam were not being monitored and indicated these were only done by exception. IDON verified that on 1/29/15 and 1/31/15, when R7 had received the lorazepam no no-pharmacological interventions trialed prior to medication and effectiveness had been documented. IDON acknowledged the nurses were supposed to document the interventions tried and do a follow up on the effectiveness of the medication. At 9:51 a.m. R7's primary physician was called but was not available.

R2's Physician Order Report dated and signed by the physician 1/13/15, indicated R2 had an order for Zoloft 75 mg by mouth once a day for depressive disorder.

R2's annual MDS dated 12/25/14, indicated R2 had intact cognition, had no presence of mood symptoms and MDS indicated R2 received an antidepressant seven days a week.
CAAs for psychotropic medication use, dated 1/19/15, identified R2 received an antidepressant and had increased fall risk as a result. Annual MDS 3.0 Notes Report behavior note dated 1/12/15, indicated staff interviews had indicated R2 continued to have episodes of inappropriate use of the rest room but no side effect documentation was addressed.

R2's care plan dated 10/2/14, indicated R2 received an antidepressant, Zoloft, related to depression. The care plan directed staff to give antidepressant medications as ordered by physician, to monitor/document side effects and effectiveness and listed antidepressant side effects including dry mouth, dry eyes, constipation, urinary retention, suicidal ideations.

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R2's MARs from 8/1/14 through 2/5/15, revealed no side effect monitoring was being completed.

On 2/4/15 at 7:40 a.m. R2 was observed lying in bed facing the window, with the television on. When interviewed, R2 indicated eating breakfast quick and not a lot because stomach was hurting and wanted to lay down for a little bit until dinner time. R2 was asked if familiar with the medications she was taking and stated she thought she received medications for heart, diabetes, some vitamins and not sure of the others. When asked how R2 was feeling, R2 indicated her mood was very good and did not feel sad or hopeless. When asked if staff had discussed any side effects of the medications she was taking R2 indicated probably but would not remember.

During interview on 2/5/15, at 8:50 a.m. LPN-B stated when a resident was first started on an antipsychotic, antidepressant or anti-anxiety medication, behavior monitoring and side effects are monitored each shift for one week and after that side effects are monitored by exception when and staff noticed any would write a nurses note and update the doctor immediately.

R12's diagnoses included depressive disorder, anxiety, Alzheimer's, which were addressed on physician's orders dated 12/27/14. MDS dated 11/21/14 indicated R12 had severe cognitive impairment, no mood symptoms and received an antidepressant seven days a week. CAA's dated 2/18/14 indicated R12 had diagnoses for major depressive disorder, sundowners, anxiety, that she should be monitored for repetitive questions, obsessive concerns, sadness and teary eyed.

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F 329	Continued From page 7 On 2/4/15, at 7:40 a.m. R12 was observed to ask the nurses if it was time for breakfast. R12 walked to the dining room, ate breakfast and at 8:03 a.m. R12 was sitting and reading a newspaper in the dayroom next to another resident on the couch. At 1:35 p.m. R12 was observed going to an activity with other residents to make valentine boxes. R12's care plan dated 1/9/15, indicated R12 was at risk for side effects and /or adverse drug reactions related to depression and anxiety and the goal was to be at the lowest effective dose to control symptoms without any adverse side effects. The quarterly assessment dated 12/15/14 indicated R12 was on "Effexor - 150 mg, and d/c'd Klonopin (anti-anxiety medication) in October. Adverse effects." The current MAR dated 1/29/15-2/28/15, indicated R12 was receiving Effexor XR (anti-depressant) 150 mg oral (by mouth) once a day and Remeron (anti-depressant) 7.5 mg oral once a day starting 1/23/15 and increased to 15 mg on 2/5/15 once a day for major recurrent depressive disorder. Monthly Medication Regimen Review revealed the consultant pharmacist had reviewed R12's medications monthly, however had not indicated side effect monitoring was lacking for the antidepressant medications R12 was receiving. During an interview on 2/5/15, at 8:51 a.m., the IDON stated that side effects are charted by	F 329		

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exception and that when the physician visits she goes around and asks everyone if they noticed anything. IDON verified there was not side effect documentation.

R35 was observed on 2/5/15, at 8:18 a.m. in room, awake and dressed. When asked how she was today R35 stated "she didn't know yet." R35 walked down the hall toward dining room, stopped to talk to LPN-A and indicated she needed a haircut. LPN-A stated she would inform hairdresser today or she would assist R35 after breakfast. R35 walked into dining room and sat down at table.

Review of R35's Admission Record dated 12/30/14, indicated admission on 1/27/14, with diagnoses of Alzheimer's disease, and anxiety. R35's MDS dated 11/5/14, revealed moderate cognitive impairment. The care plan, dated 1/27/14, indicated "impaired cognition related to Alzheimer's dementia with severe cognitive impairment, to remain safe with meeting daily needs ongoing. On Aricept which was used for Alzheimer's disease. Care plan identified monitoring for behaviors of pacing, statements of anxiety, and agitation. Care plan identified fall risk related to Alzheimer's dementia with "episodes of wandering and inappropriate behavior."

Mahnomen Health Center quarterly dated 8/4/14, indicated "psychotropic medication review: care plan established Zoloft for anxiety, and Klonopin [an antianxiety medication] prn - used 4 times in July."

The Center for Psychiatric Care progress notes were reviewed from 9/24/14, going forward:

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1. On 9/24/14, indicated "establish care and follow-up dementia and agitation. Mood generally good, anxiety, aggression, review of symptoms: depression, mania, mood, delusions, GAD [generalized anxiety disorder], dementia."
2. On 12/18/14, the note read, "Recheck mood/medication. Mood was good anxious, behaviors: agitation, medications: Zoloft, Aricept, Klonopin, review of symptoms: depression, GAD, and dementia. Medication changes: Increase Zoloft if anxiety continued to be problem, then can increase to 75 mg or can add Namenda [used to treat dementia associated with Alzheimer's disease], therapies per routine."
3. On 1/23/15, indicated "Mood good, no aggression, more wandering, boundary intrusive, review of symptoms: depression, GAD, dementia. Medication changes: consider Namenda for dementia/anxiety. Aricept is maxed, got side effect higher dose, could increase Zoloft if needed."

Review of R35's Mahnomen Health Center Interdisciplinary progress notes from 11/17/14, going forward indicated the following:
1. On 11/15/14, indicated R35 had wandered during day in hallways and others rooms.
2. On 11/17/14, indicated R35 had gone into other resident's rooms.
3. On 11/29/14, indicated R35 had been removed from other resident's rooms.

Review of the MAR for October, November and December 2014, January and February 2015, revealed daily target behavior monitoring for "wandering outside or inappropriate areas, pacing, fidgeting, nervousness, agitation, crying, negative statements, signs or symptoms of depression." Monthly target behavior monitoring

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F 329	Continued From page 10 had been documented for day, afternoon, and night shifts. The signed Physician Order Report dated 12/1/14 through 12/31/14, indicated "Clonazepam (an anti-anxiety medication) 0.5 mg three times a day (TID) PRN for anxiety, Aricept (used for Alzheimer's disease) 10 mg once daily and Zoloft 50 mg once daily for anxiety." The CAA dated 2/5/15, indicated R35 received Aricept for dementia, needed supervision for safety and history of wandering, and had impaired cognition with Alzheimer's with episodes of wandering. On 2/5/15, at 10:10 a.m. the IDON stated was uncertain where side effects were being monitored and documented. On 2/5/15, at 12:08 p.m. via telephone the consultant pharmacist (CP) stated she would expect, when medication doses change, staff would monitor for side effects and effectiveness with quarterly changes. Problematic Behavior Management- Clinical Protocol revised 03/2013, directed "4. The nursing staff and the Physician will monitor for side effects and complications related to psychoactive medications; for example lethargy, abnormal involuntary movements ..."	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local	F 371		2/5/15

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F 371	Continued From page 11 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly store food in the activity refrigerator and maintain sanitation in the walk in cooler that would minimize the possibility of food borne illness. This had the potential to affect 26 of 26 residents who were served food out of the kitchen. Findings include: During tour on 2/2/15 at 1:20 p.m. the following was observed and confirmed by the dietary manager (DM): Two exhaust cooler fans approximately one and one half (1 1/2) feet in diameter located on the back upper wall of the walk in cooler had a heavy buildup of hanging dust and debris particles. There was also a buildup of heavy dust particles above and around each fan. The fans were blowing air on 2 trays on the top shelf of two push carts holding preportioned, uncovered resident drinks in plastic drinking cups. The first cart had 16 cups of milk, four cups of grape juice, three cups of apple juice, two cups of cranberry juice and one cup of thickened strawberry kiwi juice. The second cart had 18 plastic cups of water on the top shelf of the cart.	F 371	Exhaust cooler; Dietary will add the cleaning of the condenser fans to it's cleaning list, to be completed by maintenance every 6 months, upon direction of the Dietary Staff. This was added to the policy, "Cleaning Refigerators." Dietary staff educated on 2/24/15 at 2:00pm with Registered Dietician Present. Maintenance cleaned the existing coil/fan blades, 2/5/2015 pm. Quality Indicatior (QI) will be monitored by Dietary Staff. Uncovered glasses: Dietary staff will not be allowed to prefill glasses to set in the cooler or elsewhere. Glasses are to be filled at the time of serving meals. Policy "Food Preparation and Service," changed to reflect this procedure. Practice changed effective 2/6/15. QI will be completed by Dietary Dept to monitor process for compliance. All Dietary staff educated on 2/24/15, 2pm with R.D present. Dated foods; Dietary Staff are to check all ares for outdates, including the Icecream Freezer. Specific wording added to Dietary Dept's, "Infection Control" policy.	

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F 371	Continued From page 12 The ice cream freezer contained an undated, 1/4 full, three gallon cardboard container of strawberry icecream with a partially open and unsealable cardboard top cover. The delivery date on the product was 9/10/14. Refrigerator in the activity room had expired, undated and unsealed foods with a freezer and refrigerator temperature logs recorded for January 2-11 and notice that stated "Attention: Residents, Family and Staff! All food in this refrigerator must be dated with the date it was put into the refrigerator and the date it was opened. Please use the attached Sharpie to mark your food items or ask someone from activities or nursing to assist you. Every day the food will be monitored for undated food items. If any food is found without a date, it will be thrown away for your safety." - freezer contained two resident cold packs and two 4 ounce chocolate magic cups. - refrigerator contained: approximately 1/2 full opened, undated 8 ounce bottle of Ensure Plus; two ounces grapefruit juice in uncovered, undated plastic cup; 4 ounce Mighty Shake, unopened, expired 7/14, one rotting orange, three shriveled up lemons, approximately 5 cups brown sugar undated, covered with loose plastic wrap in plastic container, approximately 4 cups white sugar undated, uncovered in plastic container; 1/4 full of 12 ounce bottle of onion and peppercorn dressing, opened, undated; 1/4 full of 12 ounce bottle of blue cheese dressing, opened, undated; two 5-pack bags of white bagels, undated, sealed; one bag of 3 bagels, opened, undated. Review of the facility Purchasing, Receiving and Storage policy with revision date 3/2013 indicated	F 371	QI will be completed by Dietary Dept to monitor all areas of food storage for outdates. Staff educated on 2/24/2015 at 2pm with R.D. present. Activity Fridge; The Activity Room fridge will no loger be used for food storage for residents, family or staff. Sign was placed on Activity Fridge notifying that residents needed to use the resident fridge in the dinning room, where proper monitoring and temperature recording occurs and is maintained.Staff educated 2/24/2015 at 2pm with the R.D. present and at the NH Staff on 2/23/2015. Food was removed and cleaned from the fridge 2/6/2015.	

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F 371	Continued From page 13 "all food will be stored in areas protected from contamination by condensation, leakage, drainage, rodents, or vermin." Review of the facility Activity Room Refrigerator policy with revision date of 3/2013 indicated that all food items will be dated prior to placement in the activity room refrigerator and freezer with names of the person to whom they belong written on the package, that activity staff will check the refrigerator and freezer daily for items not marked with a name and date or opened date if applicable and these items will be discarded, that all outdated items will be discarded and that activity staff will monitor refrigerator and freezer temperatures on a daily basis. During interview on 2/2/15, at 1:20 p.m. the DM stated she did not know when the fans were last cleaned and that maintenance was responsible for the cleaning of equipment. DM stated she did not know why they pour the beverages ahead of time and that they should have been covered before they were stored in the cooler. DM verified that the ice cream should have been dated and been able to be sealed properly. DM stated she didn't know where the ice cream came from, "I think that it is used by activities." DM removed the expired mighty shake from the activity refrigerator and stated she was not in charge of this refrigerator and that the activity director should be asked questions regarding this refrigerator. On 02/03/2015, at 9:23 a.m. all above contents were still in the activity refrigerator. During interview on 2/3/15, at 12:31 p.m. the registered dietitian (RD) verified that the dirty fans did present a possible contamination issue for the	F 371		

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pre-poured beverages and that staff should have used towels to cover the trays. RD stated that dietary was not responsible for the activity refrigerator, however they did have a situation in late December 2014 of missing food from the dining room resident refrigerator, thus resident sandwiches, drinks and supplements were moved in the activity refrigerator for storage for a short period. RD stated it was an issue to have resident ice packs and nutritional supplements stored in the same freezer, "that is not good."

During an interview on 2/3/15 at 10:19 a.m., the activity director (AD) stated the refrigerator in the activity room is for staff only and that she was responsible for it. AD stated the magic cups were in the freezer for only "about a week in January" when the director of nursing and social services decided to move resident food such as sandwiches and supplements from the dining room refrigerator to the activity refrigerator because someone from the hospital section of the complex was taking food. AS stated she did not know where the cold packs came from, normally the nursing staff provides them and "they shouldn't have been in there." AD stated "I came in one day and the refrigerator was full of food, dietary was monitoring the temperatures at that time."

During the followup kitchen tour on 2/4/15, at 12:22 p.m. the following was observed and confirmed by the dietary manager (DM):

- the same heavily dusty condenser fans in the walk in cooler were blowing directly on 28 prepoured uncovered water cups in plastic cup on the top shelf of a push cart.

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F 371	Continued From page 15 During interview on 2/3/15, at 9:23 a.m. the DM stated that she and the registered dietitian talked with staff on Monday about this issue. "I don't know what to say." During interview on 2/4/15, at 2:56 p.m. maintenance (M-A) verified the fans needed cleaning and that they should be cleaned every four to six months because compressors can burn out. "I try to do a quarterly check everywhere." M-A stated dietary should report it. "They are in there everyday and see it." M-A stated he did not have a maintenance kitchen equipment policy or cleaning schedule.	F 371		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility consultant pharmacist failed to identify medications irregularity regarding adequate monitoring for 4 of 5 residents (R7, R2, R12 and R35) who used antidepressants and antianxiety. In addition failed to consistently measure heart rate (pulse) and blood pressure as	F 428	R7's perameters were discontinued due to MD's consideration for stable v.s on 2-12-15. Med passing staff educated on 2/6/15 to continue V.S parameters for medication until MD orders them D/C'd. Staff inservice on 2/24/15 on process. Plan added to existing Medication	2/12/15

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F 428	Continued From page 16 ordered by physician was monitored for 1 of 3 residents (R7) reviewed for unnecessary medications. Findings included: The facility did not monitor and obtain the needed pulse and blood pressure to ascertain if the medication was effective or not effective for R7. R7's Physician Order Report signed and dated 1/13/15, revealed R7 had the following orders for diagnosis of Atrial Fibrillation: Amiodarone 100 milligrams (mg) hold if systolic blood pressure (SBP) was less than 100 and Lopressor 12.5 mg Hold if SBP was less than 100 and pulse rate (PR) less than 60. R7's care plan dated 7/19/11, identified R7 had a diagnosis of hypertension and had prescribed antihypertensive medications daily. The care plan directed staff to give anti-hypertensive medications as ordered, monitor for increased heart rate, effectiveness and to obtain blood pressure readings under the same conditions each time. Medication Administration Records (MAR's) from September 2014, through February 2015, lacked documentation that blood pressures or pulse readings had been done prior to medication administration. R7 was observed on 2/4/15 between 7:21 a.m. and 2:00 p.m. During this time, upon rising from bed, R7 ate breakfast in the dining room, attended activities in the television lounge and	F 428	Administration policy and Antipsychotic Medication Policy amended. QI to monitor relation to parameters to EMar, with goal of 100% compliance to be reported to QI comm by Consulting Pharamacist. Pharmacist provided staff education on 2/12/15, non-pharm interventions to try before giving an antipsych medication, documenting the medication given if needed, outcome of the medication, proper documentation, dose reduction as an effort to reduce antipsyc meds. QI of nursing and Consulting Pharmacist to monitor unnecessary psych meds, reported to QI committe meeting with goal of 100% compliance. Side effects of antipsych,depressants and anxiety meds. Inservice completed by Consulting Pharmacist on 2/12/15 of side effects to watch for, document, report and med manage. List of meds' side effects placed on all medication carts. Staff meeting held to inform all staff of side effects to meds and reporting process to nursing 2/24/15. Medication Administration and Antipsychotic Medication Policies amended. QI monitoring will be conducted by nursing and Cunsulting Pharmacist and reported at QI committee meeting for 100% compliance.	

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was assisted to the bathroom by NA-A. R7 was noted to doze off and on during the morning activities. At 2:00 p.m. R7 was observed lying in bed with eyes covered with a blanket. At 2:14 p.m. R7 was observed with eyes open and started to rub eyes. Interview with R7 at this time when asked if R7 was tired stated, "am always tired and sleepy all the time."

On 2/4/15, at 8:43 a.m. licensed practical nurse (LPN)-A was interviewed and indicated she had already administered R7's medications. When asked what R7's blood pressure and pulse readings had been prior to administering medications LPN-A explained that R7's readings for blood pressure and pulse had been stable and that the vital signs were only done once a month and had not been done this morning.

On 2/5/15, at 9:00 a.m. the interim director of nursing (IDON) verified R7's orders had directions for checking the blood pressure and pulse and acknowledged the vital signs were supposed to be checked prior to medication administration to assure they were within range. IDON verified that blood pressure and pulse had not been taken before administration of medications since September 2014.

R7's Physician Order Report signed and dated 1/13/15, also revealed R7 had the following orders: Zoloft 100 mg once daily for depression and Lorazepam (Ativan) 0.5 mg once a day as needed (PRN) for anxiety.

R7's quarterly, annual, interdisciplinary notes dated 6/1/14 through 2/5/15, lacked evidence of documentation for monitoring of side effects for Zoloft and lorazepam R7 received.

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F 428	Continued From page 18 R7's Psychotropic drug use Care Area Assessment (CAA) dated 4/3/14, identified R7 used Zoloft (antidepressant) and Ativan (lorazepam-anti-anxiety medication) as needed (PRN) and directed staff to use non-formulary interventions such as distraction, activities to distract R7 when complaining of eye problems prior to using Ativan. Psychotropic medication use care plan dated 7/19/11, identified R7 was at risk for side effects and/or adverse reactions due to daily use of antidepressant medication and use of as needed antianxiety medication. The care plan directed staff to administer medications as ordered, monitor and document side effects and effectiveness. Review of the MAR indicated R7 had received lorazepam, as needed dose, on 9/29/14, 1/29/15, and 1/31/15, and no non-pharmacological interventions prior to administering medication and effectiveness had been documented on 1/29/15, and 1/31/15. On 2/5/15, at 9:00 a.m. the interim director of nursing (IDON) , verified side effects monitoring for Zoloft and lorazepam were not being monitored and indicated these were only done by exception. IDON verified that on 1/29/15 and 1/31/15, when R7 had received the lorazepam no no-pharmacological interventions trialed prior to medication and effectiveness had been documented. IDON acknowledged the nurses were supposed to document the interventions tried and do a follow up on the effectiveness of the medication. At 9:51 a.m. R7's primary physician was called but was not available. On 2/5/15, at 12:17 p.m. when asked what her	F 428		

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expectation was of nurse with using non-pharmacological interventions prior to using Lorazepam as needed order, the CP stated via a telephone call she expected the nurses to document interventions behind a sheet in the MAR and the effectiveness of medication after administration.

R2's diagnoses included depression, vascular dementia vascular, osteoporosis and cerebrovascular disease obtained from Resident Admission Record dated 12/29/14.

R2's Physician Order Report dated and signed by the physician 1/13/15, indicated R2's had an order for Zoloft 75 mg by mouth once a day for depressive disorder.

R2's annual Minimum Data Set (MDS) dated 12/25/14, indicated R2's had intact cognition, had no presence of mood symptoms and MDS indicated R2 received an antidepressant seven days a week. Care Area Assessment (CAA) for psychotropic medication use dated 1/19/15, identified R2 received an antidepressant and had increased fall risk as a result. R2's care plan dated 10/2/14, indicated R2 received an antidepressant Zoloft related to depression. The care plan directed staff to give antidepressant medications as ordered by physician, to monitor/document side effects and effectiveness and listed antidepressant side effects including dry mouth, dry eyes, constipation, urinary retention, suicidal ideation's.

On 2/4/15 at 7:40 a.m. R2 was observed lying in bed facing the window, with the television on. When interviewed, R2 indicated eating breakfast quick and not a lot because stomach was hurting

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and wanted to lay down for a little bit until dinner time. R2 was asked if familiar with the medications she was taking and stated she thought she received medications for heart, diabetes, some vitamins and not sure of the others. When asked how R2 was feeling, R2 indicated her mood was very good and did not feel sad or hopeless. When asked if staff had discussed any side effects the medications she was taking R2 indicated probably but would not remember.

Review of the Annual MDS 3.0 Notes Report behavior note dated 1/12/15, indicated staff interviews had indicated R2 continued to have episodes of inappropriate use of the rest room but no side effect documentation was addressed. R2's Medication Administration Records (MAR's) from 8/1/14, through 2/5/15, it was lacked documentation of side effects monitoring. Pharmacist Medication Regimen Review monthly review revealed the consultant pharmacist (CP) had last completed on 1/20/15, and the CP had not identified the medical record lacked evidence of side effects monitoring.

On 2/5/15, at 8:50 a.m. LPN-B stated when a resident was first week started on a antipsychotic, antidepressant or anti-anxiety medication, behavior monitoring and side effects are monitored each shift for one week and after that side effects are monitored by exception when the staff noticed any and would write a nurses note and update the doctor immediately.

R12's physician's orders dated 12/27/14 addressed diagnoses that included depressive disorder, anxiety, Alzheimer's. The MDS dated

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11/21/14 indicated R12 had severe cognitive impairment, no mood symptoms and received an antidepressant seven days a week. CAA's dated 2/18/14 indicated R12 had diagnoses for major depressive disorder, sundowners, anxiety, that she should be monitored for repetitive questions, obsessive concerns, sadness and teary eyed.

On 2/4/15, at 7:40 a.m. R12 was observed to ask the nurses if it was time for breakfast. R12 walked to the dining room, ate breakfast and at 8:03 a.m. R12 was sitting and reading a newspaper in the dayroom next to another resident on the couch. At 1:35 p.m. R12 was observed going to an activity with other residents to make valentine boxes.

R12's care plan dated 1/9/15, indicated R12 was at risk for side effects and /or adverse drug reactions related to her depression and anxiety and the goal was to be at the lowest effective dose to control symptoms without any adverse side effects.

The current MAR dated 1/29/15-2/28/15, indicated R12 was receiving Effexor XR (anti-depressants) 150 mg oral (by mouth) once a day and Remeron (anti-depressant) 7.5 mg oral once a day starting 1/23/15 and increased to 15 mg on 2/5/15 once a day for major recurrent depressive disorder.

The quarterly assessment dated 12/15/14 indicated R12 was on "Effexor - 150 mg, d/c'd Klonopin (anti-anxiety medication) in October. Adverse effects."

Monthly Medication Regimen Review revealed the consultant pharmacist had reviewed R12's

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medications monthly, but had not indicated side effect monitoring was lacking for the antidepressant medications R12 was receiving.

During an interview on 2/5/15, at 8:51 a.m., the IDON stated side effects are charted by exception and that when the physician visits she goes around and asks everyone if they notice danything. IDON verified they don't have side effect documentation.

R35 was observed on 2/5/15, at 8:18 a.m. in room, awake and dressed. When asked how she was today R35 stated "she didn't know yet." R35 walked down hall toward dining room, stopped to talk to LPN-A and indicated needing a haircut. LPN-A stated would inform hairdresser today or would assist R35 after breakfast. R35 walked into dining room and sat down at table.

Review of R35's Admission Record dated 12/30/14, indicated admission on 1/27/14, with diagnoses of Alzheimer's disease, and anxiety. R35's MDS dated 11/5/14, revealed moderate cognitive impairment. The care plan, dated 1/27/14, indicated "impaired cognition related to Alzheimer's dementia with severe cognitive impairment, to remain safe with meeting daily needs ongoing. On Aricept which was used for Alzheimer's disease. Care plan identified monitoring for behaviors of pacing, statements of anxiety, and agitation. Care plan identified fall risk related to Alzheimer's dementia with "episodes of wandering and inappropriate behavior."

The Center for Psychiatric Care progress notes were reviewed from 9/24/14, going forward and the following was noted:
1. On 9/24/14, indicated "establish care and

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follow-up dementia and agitation. Mood generally good, anxiety, aggression, review of symptoms: depression, mania, mood, delusions, GAD [generalized anxiety disorder], dementia."

2. On 12/18/14, the note read, "Recheck mood/medication. Mood was good-anxious, behaviors: agitation, medications: Zoloft, Aricept, Klonopin, review of symptoms: depression, GAD, and dementia. Medication changes: Increase Zoloft if anxiety continued to be problem, then can increase to 75 mg or can add Namenda [used to treat dementia associated with Alzheimer's disease], therapies per routine."

3. On 1/23/15, indicated "Mood good, no aggression, more wandering, boundary intrusive, review of symptoms: depression, GAD, dementia. Medication changes: consider Namenda for dementia/anxiety. Aricept is maxed, got side effect higher dose, could increase Zoloft if needed."

Review of R35's Mahnomen Health Center Interdisciplinary progress notes from 11/17/14, going forward indicated the following:
1. On 11/15/14, indicated R35 had wandered during day in hallways and others rooms.
2. On 11/17/14, indicated R35 had gone into other resident's rooms.
3. On 11/29/14, indicated R35 had been removed from other resident's rooms.

Review of the MAR for October, November and December 2014, January and February 2015, revealed daily target behavior monitoring for "wandering outside or inappropriate areas, pacing, fidgeting, nervousness, agitation, crying, negative statements, signs or symptoms of

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depression." Monthly target behavior monitoring had been documented for day, afternoon, and night shifts.

Signed Physician Order Report dated 12/1/14 through 12/31/14, indicated "Clonazepam (an anti-anxiety medication) 0.5 mg three times a day (TID) PRN for anxiety, Aricept (used for Alzheimer's disease) 10 mg once daily and Zoloft 50 mg once daily for anxiety."

The CAA dated 2/5/15, indicated R35 received Aricept for dementia, needed supervision for safety and history of wandering, and had impaired cognition with Alzheimer's with episodes of wandering.

During review of the Pharmacist's Drug Regimen Review it was revealed the consultant pharmacist had completed the last monthly review on 1/20/15, and side effect monitoring for psychotic medications R35 was receiving on a daily basis were not being monitored.

On 2/5/15, at 10:10 a.m. the IDON stated was uncertain where side effects were being monitored and documented.

On 2/5/15, at 12:08 p.m. via telephone the consultant pharmacist (CP) stated she would expect when medication doses change staff was monitoring for side effects and effectiveness with quarterly changes.

Problematic Behavior Management- Clinical Protocol revised 03/2013, directed "4. The nursing staff and the Physician will monitor for side effects and complications related to psychoactive medications; for example lethargy,

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F 428	Continued From page 25 abnormal involuntary movements ..."	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		2/12/15

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F 431	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure expired medications were removed from 2 of 2 med carts, which had the potential to affect 2 residents (R9, R44) on North and also had the potential to affect residents who required stock medications of the 23 residents who resided in the facility. In addition the facility failed to ensure Fentanyl patches (a narcotic used to control pain) were destroyed in a manner to prevent potential diversion for 1 of 1 resident (R23). Findings include: South On 2/3/15, at 1:13 p.m. during medication cart storage tour was completed with licensed practical nurse (LPN)-A the following was observed: - House stock Acetaminophen 500 millligram (pain reliever and fever reducer) 100 quantity bottle caplets with expiration date of 4/14. - House stock Acetaminophen 500 mg 500 quantity bottle caplets with expiration date of 3/14. On 2/3/15, at 1:38 p.m. when asked what the facility policy was for medication destruction, LPN-A stated expired meds should be removed from the medication cart and put in the medication room in the expired medication bucket. North On 2/5/15, at 8:53 a.m. during medication cart storage tour with LPN-B the following was observed:	F 431	Expired meds; Expired meds removed by 2/5/15. Pharmacist provided inservice on 2/12/15 for routine monitoring and process for expired meds. Policy to reflect this process. QI indicator, monthly assessment for expired meds in all nursing areas, monitored by nursing and reported to QI committee meetings. Destruction of Narcotics; Destuction of narcotic inservice given 2/12/15 by consulting Pharmacist to nursing staff. Policy updated to add clarity to procedure. QI indicator to monitor destruction and proper documentation by consulting pharmacist and report to QI committe meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	02/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(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 431	Continued From page 27 R9- Senna Plus (a laxative for constipation) with expiration date of 12/13. R44- Fish oil capsules 1200 mg (supplement) with expiration date of 7/14. - House stock Acetaminophen suppository 325 mg with expiration date of 1/18/14. On 2/5/15, at 9:10 a.m. LPN-B stated she would put expired medications in the medication room in the expired medication bucket. On 2/5/15, at 10:28 a.m. LPN-A provided access to the medication cart in which the narcotic box was located. Upon opening the narcotic box two unopened boxes of Fentanyl patches of five quantity each were observed stored in a box which belonged to R23. R23's unsigned Physician Order Report dated 2/1/15, - 2/5/15, revealed R23 had an order for Fentanyl 12 microgram (mcg)/hour patch every 72 hours transdermal for osteroarthrosis. In addition the order had "special instructions: LPN must co-sign med off with another nurse when giving. Destroy by sewer system." On 2/5/15, at 10:28 a.m. both LPN-A and LPN-B stated when Fentanyl patches were removed they would cut them up and dispose them in the sharps container then one nurse would sign the narcotic book after the destruction. During review of R23's Medication Flowsheet 12/29/14, through 1/31/15, it was revealed R23 had the Fentanyl patch removed and disposed of twelve times with only one nurse signing off. It could not be determined if there were two nurses or one nurse signing off for the removal and destruction of the Fentanyl patch.	F 431		

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F 431	Continued From page 28 On 2/5/15, at 10:40 a.m. the interim director of nursing (IDON) stated "nurses must wear gloves when handling Fentanyl patches, remove old patch first with another nurse witnessing it, must rotate sites, cut up used patches and flush them. They must co-sign the narcotic book." On 2/5/15, at 12:25 p.m. the consultant pharmacist was contacted via telephone. CP stated she did not expect that nurses would dispose of Fentanyl patches in sharps container "They should be flushing them, this is the way to do it." CP stated she expected two nurses to document they had witnessed disposal of Fentanyl patches. CP further stated she had spoken to nurses about the correct disposal method. Mahnomen Health Center Storage of Medications policy indicated "4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed." Mahnomen Health Center Discarding and Destroying Medications policy indicated "2. Non-controlled and Schedule V controlled drugs must be destroyed in the presence of two (2) licensed nurses. 5. Unless otherwise instructed, flush tablets, capsules, liquids, and contents of vials and ampules down the toilet in the medication room. 6. Whoever witnesses the destruction/disposal of medications must sign and date the medication disposition record."	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		3/11/15

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F 441	Continued From page 29 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 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:	F 441		

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F 441	Continued From page 30 Based on observation, interview and document review, the facility failed to develop and operationalize an infection control program to minimize the spread and transmission of infections. In addition, the facility failed to ensure the proper handling of dirty linens and proper hand washing technique during cares for 1 of 1 resident (R37) observed for incontinence care. This had the potential to affect all 23 residents in the facility. Findings include: On 2/5/15, at 9:33 a.m. the interim director of nursing (IDON) reported the facility lacked a comprehensive infection control program. The IDON stated the facility was unable to locate the current system and corresponding paperwork for tracking and surveillance of possible infections within the facility. IDON stated a former employee who had been in charge of infection control program had taken the paperwork with her when her employment at the facility ended in 12/14. IDON further stated, "It [an infection control program] needs to be set up again. I, along with the administrator, will reinstate the infection control program." The following facility policy dated 3/13, indicated the objective of infection control policies was "...to prevent, detect, investigate and control infections in the facility, maintain a safe and comfortable environment, establish guidelines for implementing isolation and guidelines for availability of supplies and equipment necessary for standard precautions, maintain records incidents and corrective actions related to infections and provide guidelines for the safe cleaning of reusable care equipment."	F 441	Program: MHC Nursing Home's 140 Infection Control Policies were captured for safe and sanitary equipment but program had not occured since 2nd quarter 2014. All culture reports for 2014 were obtained, in their entirety by 2/24/15. NH Managers met to ensure the MHC 2015 Infection Prevention and Control Plan for 2015 was completed by 2/26/15. All nursing home department directors instructed on the 2015 Infection Control Plan on 3/2/15. An Infection Control meeting for 1st quarter 2015 is scheduled for 3/11/15 with consultant Infection Control nurse present for monitoring meeting. QI monitoring of IC meetings will occur showing compliance of quarterly meetings, required attendees, and culture reports with action planning, staff illness assessment and clearance, infection and nosocomial surveillance, antibiotic use review, value analysis of cleaning products, TB program, Resident immunization program review, system for detection, isolation, reporting, ect; equipment and instrument cleaning monitoring, sanitation audits, and prevention initiatives. Another IC meeting scheduled for 3/31/15 to present findings of 3/11/15 meeting to Medical Director by IC committee. MHC Nursing Home's 140 Infection Control Policies contain policies for safe and sanitary equipment but program meetings had not occured since 2nd quarter 2014. Policies in place. Education to Department directors completed on 2/26/15. Staff education	

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F 441	Continued From page 31 R37 was assisted with morning cares on 2/5/15, at 7:55 a.m. two nursing assistants (NA)-A and NA-B. The resident's incontinence brief was soiled with urine and stool. Following incontinence care, NA-A rolled up the wet and soiled cloth pad, and laid it on the floor next to a plastic bag of soiled disposable incontinent products. NA-A then removed her gloves and left the room and without washing her hands, retrieved a Hoyer lift (a mechanical lift for transferring). NA-A returned into R37's room proceeded to transfer the resident from the bed into his wheelchair with assistance from NA-B. NA-B had also removed her gloves, but had not washed her hands. NA-A then left the room again to obtain a wash cloth. Upon returning to room NA-A assisted R37 with the rest of his morning cares, including washing under arms and brushing his hair. NA-A then wet a wash cloth and handed to the resident to wash his face. NA-A then left the room with the Hoyer lift and NA-B made the resident's bed and tidied the room. Neither NA-A or NA-B washed their hands. Following the observations at 8:03 a.m. NA-A reported she placed the linens on the floor because she had no container in the room. She further explained she had been in a hurry because R37 was known to get anxious and she did not want to make him wait. Both NA-A and NA-B then acknowledged they were aware they should have wash their hands after removing their gloves after providing incontinence care. R37's Resident Admission Record dated 12/30/14, revealed diagnoses including septicemia (infection throughout the body) and Methicillin-resistant Staphylococcus aureus	F 441	done on 2/26/15 and again planned for staff meeting end of march 2015, with ongoing education requiring reading IC manual. Monthly staff meetings will include 1-2 infection control policies and procedures. Noncritical resident equipment cleaning QI monitoring will be done on wheelchair cleaning for 100% compliance, as per policy. Hand Washing: Staff instucted on handwashing compliance on 2/5/15 and education completed by RN on 2/26/15. Policy reviewed. Infection Control overview inservice to be completed on March staff meeting to include proper handwashing. QI monitoring set up for quarterly reporting to QI committee. Laundry: Staff instructed on soiled laundry/linen handling on 2/5/15 and education completed by RN on 2/24/15. Policy reviewed. Infection control overview inservice to be completed at March staff meeting to include proper handling of soiled laundry/linen. QI monitoring set up for quarterly and reported to QI committee.	

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F 441	Continued From page 32 (MRSA) resistive staff aureus obtained from the Resident Admission Record dated 12/30/14. The MHC Departmental (Environmental Services)-Laundry and Linen Policy and Procedure revised 3/2013 directs staff to wash hands after handling dirty linen, consider all soiled linen to be potentially infectious, place all dirty linen into a covered laundry hamper which can contain the moisture and to handle covered linen as little as possible to prevent agitation. The MHC Personal protective Equipment policy, revised 3/2013 directs all staff to wear gloves when handling blood, body fluids, secretions, excretions, mucous membranes and/or non-intact skin, when handling soiled linen that may be contaminated, and to wash hands after removing gloves. On 2/5/2015, at 10:42 a.m.. the administrator stated she expected staff to put soiled linen in a plastic bag or container and not directly on the floor. She further stated she would expect staff to always wash their hands after removing disposable gloves especially after providing peri care to residents.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by:	F 465		2/5/15

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F 465	Continued From page 33 Based on observation, interview and document review, the facility failed to ensure grab bars on resident beds, used for positioning/transfers, were maintained to assure stability for 6 of 6 residents (R32, R23, R14, R33, R37, R5) observed with grab bars. Finding include: R32's room observation was conducted on 2/3/15, at 1:52 p.m. and a grab bar on the bed was observed to be loose and wiggled back and forth when checked. R32's Care Area Assessment (CAA) dated 9/26/14, indicated an evalution for grab bars had been done and grab bars had been placed on bed following a fall that R32 had slid out of bed five days after admission. R23's room observation was conducted on 2/3/15, at 11:37 a.m. and two grab bars attached to R23's bed were observed to be loose and wiggled when checked. R23's Quarterly MDS, dated 10/4/14, indicated R23 had not had any falls and the self care deficit care plan, dated 1/13/15, directed staff to assist turning R23 using grab bars. R14's room observation was conducted on 2/3/15, at 1:52 p.m. and the covered left side grab bar attached to R14's bed was noted to be loose and wiggled approximately one inch, when checked. During interview, R14 was asked if the grab bar was used and R14, stated "its strong enough, I use it to get up." R14's activities of daily living (ADL's) care plan dated 7/18/13, directed staff for R14's bed mobility to utilize the grab bar on the left side of bed to help with positioning.	F 465	All rooms were screened by Maintenance staff and all grab bars were secured by 2/5/15. Staff educated to report any equipment concerns to RN or Maintence immediately upon observation at staff meeting on 2/24/15. Maintenance staff educated on 2/6/15. Policy developed to ensure safe operation and maintenance plan for resident-related equipment, to include both scheduled in-room assessment by maintenance staff and reporting process for clinical staff. QI indicator to monitor for 100% compliance of plan.	

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F 465	Continued From page 34	F 465		

R33's room observation was conducted on 2/3/15, at 1:50 p.m. and the right grab bar attached to R33's bed was observed to be loose and moved back and forth approximately one inch when checked. When asked, R33 indicated using the grab bar for turning self in bed. R33's care plan dated 8/22/13, directed staff for bed mobility R33 was able to turn self once in bed. On 2/4/15, at 2:35 p.m. an environmental tour was conducted with the facility director of maintenance (MD) and the loose grab bar attached to R33's bed was looked at. Interview with R33, regarding the loose grab bar, R33 explained, "I just got used to it that way. When I was in the other room it was tighter for a couple days then it got loose."

R37's room observation was conducted on 2/3/15, at 11:25 a.m. and the right grab bar attached to R37's bed was noted to be loose and wiggled when checked. R37's ADL functional/rehabilitation care plan dated 12/13/14, identified R37 was able to use grab bars to help turn side to side.

R5's room observation was conducted on 2/3/15, at 1:56 p.m. and both grab bars attached to R5's bed were observed to be loose and wiggled when checked. R5's care plan dated 6/25/13, identified R5 required extensive assist of one staff and would roll side to side with cues.

On 2/3/15, at approximately 9:47 a.m., during an interview with MD stated all grab bars in residents rooms were applied to the bed with a therapy recommendation and indicated his department applied the grab bars to the bed. When asked who made sure the grab bars were stable, MD

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F 465	Continued From page 35 stated therapy would follow up to make sure the grab bars were appropriate. On 2/4/15, at 2:35 p.m., during the environmental tour with MD, it was verified the grab bars were loose/wiggled when checked. MD stated this was how the grab bars came from the manufacture and showed surveyor the grab bars were secured with a removable pin that went through the grab bar at the bottom, which when removed the grab bar was able to fold inward. During the tour when reviewing R5's grab bars attached to the bed it was noted the grab bar by the window was tight and MD verified the grab bar was stable and tight compared to the other grab bars reviewed prior to it. Upon looking at the bolt located on top of the removable pin, MD indicated it appeared to have more thread visible and retrieved a screw driver to attempt to tighten it. At 2:45 p.m. after turning the bolt a few times MD was able to tighten the grab bar to assure stability. At 3:05 p.m. occupational therapy (OT) verified the grab bars in R14's bed were loose. When asked if this is how the grab bars were meant to be, OT indicated the grab bars were applied to the beds to assist the resident with bed mobility and not transfers. OT indicated the grab bar moved back and forth approximately one inch. Both OT and MD acknowledged the grab bars should be stable if residents used them to assist with transfers. When asked who was responsible to ensure the grab bars were tight and stable OT and MD indicated this was something the facility had not assigned to a specific department.	F 465		

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	245238	A. BUILDING **01 - 1969 BUILDING WITH 1975 ADDITION** B. WING _____	**02/05/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Mahnomen Health Center (Nursing Home) 01 Building was found in 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. Mahnomen Health Center (Nursing Home) was built at three different times. In 1969 the main building was added to the east of the Mahnomen Hospital. It is 1-story, without a basement and is Type II(111) construction. In 1996 an addition to the north of the kitchen was added, is 1-story, no basement and Type II (111) construction, In 2000, additions of 1-story, without basements and of Type II(000) construction were built to the west of the 1969 building and to the north of the 1996 building, The 1969 building is separated by a 2-hour fire barrier from the Hospital building and from the 2000 east addition. The facility has 3 smoke compartments separated by at least 30 minute fire barriers. The facility is protected with an automatic fire sprinkler system with quick response heads. The facility has a fire alarm system with corridor smoke detection, sleeping room smoke detection, and smoke detection in common areas.	K 000		

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

Electronically Signed | 03/16/2015

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

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K 000	Continued From page 1 The facility has a capacity of 48 beds and had a census of 26 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
February 24, 2015

Ms. Susan Klassen, Administrator
Mahnomen Health Center
414 West Jefferson Avenue, PO Box 396
Mahnomen, Minnesota 56557

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5238025

Dear . Klassen:

The above facility was surveyed on February 2, 2015 through February 5, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gloria Derfus at (651) 201-3792 or email: gloria.derfus@state.mn.us.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
mark.meath@state.mn.us

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00353	A. BUILDING: _____ B. WING _____	02/05/2015

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MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On December 2/2/15, through 2/5/15, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly store food in the activity refrigerator and maintain sanitation in the walk in cooler that would minimize the possibility of food borne illness. This had the potential to affect 26 of 26 residents who were served food out of the kitchen. Findings include: During tour on 2/2/15 at 1:20 p.m. the following was observed and confirmed by the dietary manager (DM): Two exhaust cooler fans approximately one and one half (1 1/2) feet in diameter located on the back upper wall of the walk in cooler had a heavy buildup of hanging dust and debris particles. There was also a buildup of heavy dust particles above and around each fan. The fans were blowing air on 2 trays on the top shelf of two push carts holding preportioned, uncovered resident drinks in plastic drinking cups. The first cart had	21015	Exhaust cooler; Dietary will add the cleaning of the condenser fans to it's cleaning list, to be completed by maintenance every 6 months, upon direction of the Dietary Staff. This was added to the policy, "Cleaning Refigerators." Dietary staff educated on 2/24/15 at 2:00pm with Registered Dietician Present. Maintenance cleaned the existing coil/fan blades, 2/5/2015 pm. Quality Indicatior (QI) will be monitored by Dietary Staff. Uncovered glasses: Dietary staff will not be allowed to prefill glasses to set in the cooler or elsewhere. Glasses are to be filled at the time of serving meals. Policy "Food Preparation and Service," changed to reflect this procedure. Practice changed effective 2/6/15. QI will be completed by Dietary Dept to monitor process for compliance. All Dietary staff educated on 2/24/15, 2pm with R.D present.	2/5/15

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21015	Continued From page 3 16 cups of milk, four cups of grape juice, three cups of apple juice, two cups of cranberry juice and one cup of thickened strawberry kiwi juice. The second cart had 18 plastic cups of water on the top shelf of the cart. The ice cream freezer contained an undated, 1/4 full, three gallon cardboard container of strawberry icecream with a partially open and unsealable cardboard top cover. The delivery date on the product was 9/10/14. Refrigerator in the activity room had expired, undated and unsealed foods with a freezer and refrigerator temperature logs recorded for January 2-11 and notice that stated "Attention: Residents, Family and Staff! All food in this refrigerator must be dated with the date it was put into the refrigerator and the date it was opened. Please use the attached Sharpie to mark your food items or ask someone from activities or nursing to assist you. Every day the food will be monitored for undated food items. If any food is found without a date, it will be thrown away for your safety." - freezer contained two resident cold packs and two 4 ounce chocolate magic cups. - refrigerator contained: approximately 1/2 full opened, undated 8 ounce bottle of Ensure Plus; two ounces grapefruit juice in uncovered, undated plastic cup; 4 ounce Mighty Shake, unopened, expired 7/14, one rotting orange, three shriveled up lemons, approximately 5 cups brown sugar undated, covered with loose plastic wrap in plastic container, approximately 4 cups white sugar undated, uncovered in plastic container; 1/4 full of 12 ounce bottle of onion and peppercorn dressing, opened, undated; 1/4 full of 12 ounce bottle of blue cheese dressing, opened, undated; two 5-pack bags of white bagels,	21015	Dated foods; Dietary Staff are to check all ares for outdates, including the Icecream Freezer. Specific wording added to Dietary Dept's, "Infection Control" policy. QI will be completed by Dietary Dept to monitor all areas of food storage for outdates. Staff educated on 2/24/2015 at 2pm with R.D. present. Activity Fridge; The Activity Room fridge will no loger be used for food storage for residents, family or staff. Sign was placed on Activity Fridge notifying that residents needed to use the resident fridge in the dinning room, where proper monitoring and temperature recording occurs and is maintained.Staff educated 2/24/2015 at 2pm with the R.D. present and at the NH Staff on 2/23/2015. Food was removed and cleaned from the fridge 2/6/2015.	

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21015	Continued From page 4 undated, sealed; one bag of 3 bagels, opened, undated. Review of the facility Purchasing, Receiving and Storage policy with revision date 3/2013 indicated "all food will be stored in areas protected from contamination by condensation, leakage, drainage, rodents, or vermin." Review of the facility Activity Room Refrigerator policy with revision date of 3/2013 indicated that all food items will be dated prior to placement in the activity room refrigerator and freezer with names of the person to whom they belong written on the package, that activity staff will check the refrigerator and freezer daily for items not marked with a name and date or opened date if applicable and these items will be discarded, that all outdated items will be discarded and that activity staff will monitor refrigerator and freezer temperatures on a daily basis. During interview on 2/2/15, at 1:20 p.m. the DM stated she did not know when the fans were last cleaned and that maintenance was responsible for the cleaning of equipment. DM stated she did not know why they pour the beverages ahead of time and that they should have been covered before they were stored in the cooler. DM verified that the ice cream should have been dated and been able to be sealed properly. DM stated she didn't know where the ice cream came from, "I think that it is used by activities." DM removed the expired mighty shake from the activity refrigerator and stated she was not in charge of this refrigerator and that the activity director should be asked questions regarding this refrigerator. On 02/03/2015, at 9:23 a.m. all above contents were still in the activity refrigerator.	21015		

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21015	Continued From page 5 During interview on 2/3/15, at 12:31 p.m. the registered dietitian (RD) verified that the dirty fans did present a possible contamination issue for the pre-poured beverages and that staff should have used towels to cover the trays. RD stated that dietary was not responsible for the activity refrigerator, however they did have a situation in late December 2014 of missing food from the dining room resident refrigerator, thus resident sandwiches, drinks and supplements were moved in the activity refrigerator for storage for a short period. RD stated it was an issue to have resident ice packs and nutritional supplements stored in the same freezer, "that is not good." During an interview on 2/3/15 at 10:19 a.m., the activity director (AD) stated the refrigerator in the activity room is for staff only and that she was responsible for it. AD stated the magic cups were in the freezer for only "about a week in January" when the director of nursing and social services decided to move resident food such as sandwiches and supplements from the dining room refrigerator to the activity refrigerator because someone from the hospital section of the complex was taking food. AS stated she did not know where the cold packs came from, normally the nursing staff provides them and "they shouldn't have been in there." AD stated "I came in one day and the refrigerator was full of food, dietary was monitoring the temperatures at that time." During the followup kitchen tour on 2/4/15, at 12:22 p.m. the following was observed and confirmed by the dietary manager (DM): - the same heavily dusty condenser fans in the walk in cooler were blowing directly on 28	21015		

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21015	Continued From page 6 prepoured uncovered water cups in plastic cup on the top shelf of a push cart. During interview on 2/3/15, at 9:23 a.m. the DM stated that she and the registered dietitian talked with staff on Monday about this issue. "I don't know what to say." During interview on 2/4/15, at 2:56 p.m. maintenance (M-A) verified the fans needed cleaning and that they should be cleaned every four to six months because compressors can burn out. "I try to do a quarterly check everywhere." M-A stated dietary should report it. "They are in there everyday and see it." M-A stated he did not have a maintenance kitchen equipment policy or cleaning schedule. SUGGESTED METHOD OF CORRECTION: The dietary director could ensure all staff have been educated and are following cleaning and reporting maintenance issues policies. Audits could be conducted and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21015		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced	21375		3/11/15

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21375	Continued From page 7 by: Based on Observation, interview and document review, the facility failed to ensure an infection control program was developed and operationalized to prevent the spread and transmission of infections. This had the potential to affect all 23 residents in the facility. Findings Include: On 2/5/15, at 9:33 a.m. the Interim Director of Nursing (IDON)indicated the facility lacked a comprehensive infection control program. The IDON stated the facility was unable to locate the current system and paperwork for tracking and surveillance of possible infection born illness within the facility. IDON stated a former employee who was in charge of infection control program had taken the infection control paperwork with her when she stopped working at the facility in December 2014. IDON further stated, "It (a infection control program) needs to be set up again. I, along with the administrator, will reinstate the infection control program." Suggested Method of Correction: The DON or her designee could review policy and procedures regarding infection control program. The DON or her designee could educate staff on policy and procedures on proper procedures for cleaning residents equipment. Time Period for Correction: Forty (40) days.	21375	Program: MHC Nursing Home's 140 Infection Control Policies were captured for safe and sanitary equipment but program had not occured since 2nd quarter 2014. All culture reports for 2014 were obtained, in their entirety by 2/24/15. NH Managers met to ensure the MHC 2015 Infection Prevention and Control Plan for 2015 was completed by 2/26/15. All nursing home department directors instructed on the 2015 Infection Control Plan on 3/2/15. An Infection Control meeting for 1st quarter 2015 is scheduled for 3/11/15 with consultant Infection Control nurse present for monitoring meeting. QI monitoring of IC meetings will occur showing compliance of quarterly meetings, required attendees, and culture reports with action planning, staff illness assessment and clearance, infection and nosocomial surveillance, antibiotic use review, value analysis of cleaning products, TB program, Resident immunization program review, system for detection, isolation, reporting, ect; equipment and instrument cleaning monitoring, sanitation audits, and prevention initiatives. Another IC meeting scheduled for 3/31/15 to present findings of 3/11/15 meeting to Medical Director by IC committee. MHC Nursing Home's 140 Infection Control Policies contain policies for safe and sanitary equipment but program meetings had not occured since 2nd quarter 2014. Policies in place. Education to Department directors completed on 2/26/15. Staff education	

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21375	Continued From page 8	21375	done on 2/26/15 and again planned for staff meeting end of march 2015, with ongoing education requiring reading IC manual. Monthly staff meetings will include 1-2 infection control policies and procedures. Noncritical resident equipment cleaning QI monitoring will be done on wheelchair cleaning for 100% compliance, as per policy.	
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of	21390		2/24/15

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21390	Continued From page 9 current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure handwashing was performed,gloves were changed after touching soiled items during the provision of cares and reusable soiled linen to prevent the spread of infection for 1 of 3 residents (R37) reviewed for incontinence. Findings include: On 2/5/15, at 7:55 a.m. R37 was assisted by nursing assistants (NA-A and NA-B) with morning cares. NA-A was observed providing incontinent cares and when she was finished, she rolled up the cloth pad, which was wet and soiled with both both urine and bowel movement and laid it on the floor next to a plastic bag of disposable, soiled incontinent products. NA-A then removed her gloves and left the room to retrieve a Hoyer lift (a mechanical lift for transferring) without washing her hands. NA-A returned into R37's room proceeded to transfer R37 from the bed to his electric wheel chair with assitance from the NA-B who had also removed her gloves after assisting with morning cares but did not wash her hands. NA-A then left the room again to get a wash cloth for R37 still no hand washing to this time. Upon returning to room this time NA-A was observed assist with R37 with the rest of his morning cares washed R37's underarms and brushed his hair. Then NA-A was observed wet a wash cloth and handed it to R37 to wash his own face left the room to return the Hoyer lift outside as NA-B made the bed and tidied the room still neither of them had washed their hands to this time.	21390	Hand Washing: Staff instucted on handwashing compliance on 2/5/15 and education completed by RN on 2/26/15. Policy reviewed. Infection Control overview inservice to be completed on March staff meeting to include proper handwashing. QI monitoring set up for quarterly reporting to QI committee. Laundry: Staff instructed on soiled laundry/linen handling on 2/5/15 and education completed by RN on 2/24/15. Policy reviewed. Infection control overview inservice to be completed at March staff meeting to include proper handling of soiled laundry/linen. QI monitoring set up for quarterly and reported to QI committee	

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21390	Continued From page 10 -At 8:03 a.m. NA-A stated she had put the soiled linens on the floor because she did not have a container with her. She further explained she was in a hurry because R37 got anxious and did not want to make him wait. Both NA-A and NA-B stated acknowledged they were aware they should have wash their hands after removing their gloves after providing incontinence care. R37's diagnoses included renal disease, peripheral vascular disease, depression disorder, heart valve transplant, diabetes mellitus type II, below knee amputation and septicemia MRSA resistive staff aureus obtained from the Resident Admission Record dated 12/30/14. The MHC Departmental (Environmental Services)-Laundry and Linen Policy and Procedure revised 3/2013 directs staff to wash hands after handling dirty linen, consider all soiled linen to be potentiallly infectious, place all dirty linen into a covered laundry hamper which can contain the moisture and to handle covered linen as little as possible to prevent agitation. The MHC Personal protective Equipment policy, revised 3/2013 directs all staff to wear gloves when handling blood, body fluids, secretions, excretions, mucous membranes and/or non-intact skin, when handling soiled linen that may be contaminated, and to wash hands after removing gloves. On 2/5/2015, at 10:42a.m. the administrator stated she expected staff to put soiled linen in a plastic bag or container and not directly on the floor. She further stated she would expect staff to always wash their hands after removing disposable gloves especially after providing peri care to residents.	21390		

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21390	Continued From page 11 Suggested Method of Correction: The DON or her designee could review policy and procedures regarding infection control program. The DON or her designee could educate staff on policy and procedures and develop a monitoring system, that included staff illness to ensure compliance with surveillance analysis and trending was completed. Time Period for Correction: Twenty one (21) days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		3/6/15

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21426	Continued From page 12 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure State guidelines to ensure Employee Tuberculosis (TB) Screening, Tuberculin Skin Test (TST) and medical evaluations for 1 of 5 employees was completed prior to employment in the facility. Findings include: A review of cook (C)-A's file revealed a hire date of 4/29/14. The file lacked evidence of a TB screening tool, a TST or a medical evaluation or a chest x-ray, in the time period three months prior to employment to present had been completed. On 2/5/15, at 9:10 a.m. the director of human resources verified C-A had worked in the facility for nine months and was still currently employed by the facility. She verified the facility lacked evidence of tuberculin skin test completion and documentation of results. She stated, "I believe she had a two-step and a screening but am not able to locate it right now. I will have her redo it." She further explained staff is responsible to make sure the second step is completed. Director of human resource further stated "There has been some fall through ensuring the second step is getting done. Obviously we have to look at why this is falling through. The nurse who followed TB has left and nobody has taken over. I periodically look it over and e-mail the supervisors but there is no follow through." On 2/5/15, at 10:00 a.m. the interim director of nursing (IDON) stated new employees do the first step of the TST when they come in to do rehire paperwork and the human resource department	21426	All employees missing completed 2-step TN skin test series, or missing, will have them redone by 3/6/15. Policy "Mahnomen Health Center TB Screening Program", effective 6/2001 reflects the addition of the process whereby HR initiates the process and the Director of Nursing is responsible for surveillance and completion. Tracking tools in place. NH and HR staff educated on 2/23/15; dietary staff educated 2/24/15. Facility QI committee to monitor compliance on a quarterly basis.	

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21426	Continued From page 13 is ultimately responsible to ensure the second step is complete. The Mahnomen Health Center TB Screening Program policy revised 3/2013 instructs for all paid and unpaid healthcare workers will receive baseline TB screening at the time of hire. Baseline screening includes a written assessment of the Health care worker's (HCW's) current symptoms of active TB disease and two-step tuberculin test (TST). During an interview with at 10:30 a.m. the administrator stated, "Nursing feels it is HR's responsibility to ensure the second-step is done and visa versa. There is no system. It isn't working." SUGGESTED METHOD FOR CORRECTION: The Director of Nursing and/or designee could monitor to assure tuberculin screening procedures were developed and implemented to ensure staff was free of tuberculosis prior to working with residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration;	21535		2/6/15

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21535	Continued From page 14 C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to consistently measure heart rate (pulse) and blood pressure as ordered by the physician to monitor the effectiveness of a blood pressure lowering medication for 1 of 3 residents (R7). In addition, the facility failed to ensure 4 of 5 residents (R7, R2, R12, R35), reviewed for unnecessary medications, who took antidepressants and anti-anxiety medications had adequate monitoring. Findings include: The facility did not monitor and obtain the needed pulse and blood pressure to ascertain if the medication was effective or not effective for R7. R7's Physician Order Report signed and dated 1/13/15, revealed R7 had the following orders for	21535	R7's perameters were discontinued due to MD's consideration for stable v.s on 2-12-15. Med passing staff educated on 2/6/15 to continue V.S parameters for medication until MD orders them D/C'd. Staff inservice on 2/24/15 on process. Plan added to existing Medication Administration policy and Antipsychotic Medication Policy amended. QI to monitor relation to parameters to EMar, with goal of 100% compliance to be reported to QI comm by Consulting Pharamacist. Pharmacist provided staff education on 2/12/15, non-pharm interventions to try before giving an antipsych medication, documenting the medication given if needed, outcome of the medication, proper documentation, dose reduction as an effort to reduce antipsyc meds. QI of	

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21535	Continued From page 15 diagnosis of Atrial Fibrillation: Amiodarone 100 milligrams (mg) hold if systolic blood pressure (SBP) was less than 100 and Lopressor 12.5 mg Hold if SBP was less than 100 and pulse rate (PR) less than 60. R7's care plan dated 7/19/11, identified R7 had a diagnosis of hypertension and had prescribed antihypertensive medications daily. The care plan directed staff to give anti-hypertensive medications as ordered, monitor for increased heart rate, effectiveness and to obtain blood pressure readings under the same conditions each time. Medication Administration Records (MAR's) from September 2014, through February 2015, lacked documentation that blood pressures or pulse readings had been done prior to medication administration. R7 was observed on 2/4/15 between 7:21 a.m. and 2:00 p.m. During this time, upon rising from bed, R7 ate breakfast in the dining room, attended activities in the television lounge and was assisted to the bathroom by NA-A. R7 was noted to doze off and on during the morning activities. At 2:00 p.m. R7 was observed lying in bed with eyes covered with a blanket. At 2:14 p.m. R7 was observed with eyes open and started to rub eyes. Interview with R7 at this time when asked if R7 was tired stated, "am always tired and sleepy all the time." On 2/4/15, at 8:43 a.m. licensed practical nurse (LPN)-A was interviewed and indicated she had already administered R7's medications. When asked what R7's blood pressure and pulse readings had been prior to administering	21535	nursing and Consulting Pharmacist to monitor unnecessary psych meds, reported to QI committe meeting with goal of 100% compliance. Side effects of antipsych,depressants and anxiety meds. Inservice completed by Consulting Pharmacist on 2/12/15 of side effects to watch for, document, report and med manage. List of meds' side effects placed on all medication carts. Staff meeting held to inform all staff of side effects to meds and reporting process to nursing 2/24/15. Medication Administration and Antipsychotic Medication Policies amended. QI monitoring will be conducted by nursing and Cunsulting Pharmacist and reported at QI committee meeting for 100% compliance.	

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medications LPN-A explained that R7's readings for blood pressure and pulse had been stable and that the vital signs were only done once a month and had not been done this morning.

On 2/5/15, at 9:00 a.m. the interim director of nursing (IDON) verified R7's orders had directions for checking the blood pressure and pulse and acknowledged the vital signs were supposed to be checked prior to medication administration to assure they were within range. IDON verified that blood pressure and pulse had not been taken before administration of medications since September 2014.

R7's Physician Order Report signed and dated 1/13/15, also revealed R7 had the following orders: Zoloft 100 mg once daily for depression and Lorazepam (Ativan) 0.5 mg once a day as needed (PRN) for anxiety.

R7's quarterly, annual, interdisciplinary notes dated 6/1/14 through 2/5/15, lacked evidence of documentation for monitoring of side effects for Zoloft and lorazepam R7 received.

R7's Psychotropic drug use Care Area Assessment (CAA) dated 4/3/14, identified R7 used Zoloft (antidepressant) and Ativan (lorazepam-anti-anxiety medication) as needed (PRN) and directed staff to use non-formulary interventions such as distraction, activities to distract R7 when complaining of eye problems prior to using Ativan. Psychotropic medication use care plan dated 7/19/11, identified R7 was at risk for side effects and/or adverse reactions due to daily use of antidepressant medication and use of as needed antianxiety medication. The care plan directed staff to administer medications as ordered, monitor and document side effects and

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21535	Continued From page 17 effectiveness. Review of the MAR indicated R7 had received lorazepam, as needed dose, on 9/29/14, 1/29/15, and 1/31/15, and no non-pharmacological interventions prior to administering medication and effectiveness had been documented on 1/29/15, and 1/31/15. On 2/5/15, at 9:00 a.m. the interim director of nursing (IDON) , verified side effects monitoring for Zoloft and lorazepam were not being monitored and indicated these were only done by exception. IDON verified that on 1/29/15 and 1/31/15, when R7 had received the lorazepam no no-pharmacological interventions trialed prior to medication and effectiveness had been documented. IDON acknowledged the nurses were supposed to document the interventions tried and do a follow up on the effectiveness of the medication. At 9:51 a.m. R7's primary physician was called but was not available. R2's Physician Order Report dated and signed by the physician 1/13/15, indicated R2 had an order for Zoloft 75 mg by mouth once a day for depressive disorder. R2's annual MDS dated 12/25/14, indicated R2 had intact cognition, had no presence of mood symptoms and MDS indicated R2 received an antidepressant seven days a week. CAAs for psychotropic medication use, dated 1/19/15, identified R2 received an antidepressant and had increased fall risk as a result. Annual MDS 3.0 Notes Report behavior note dated 1/12/15, indicated staff interviews had indicated R2 continued to have episodes of inappropriate use of the rest room but no side effect documentation was addressed.	21535		

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21535	Continued From page 18 R2's care plan dated 10/2/14, indicated R2 received an antidepressant, Zoloft, related to depression. The care plan directed staff to give antidepressant medications as ordered by physician, to monitor/document side effects and effectiveness and listed antidepressant side effects including dry mouth, dry eyes, constipation, urinary retention, suicidal ideations. R2's MARs from 8/1/14 through 2/5/15, revealed no side effect monitoring was being completed. On 2/4/15 at 7:40 a.m. R2 was observed lying in bed facing the window, with the television on. When interviewed, R2 indicated eating breakfast quick and not a lot because stomach was hurting and wanted to lay down for a little bit until dinner time. R2 was asked if familiar with the medications she was taking and stated she thought she received medications for heart, diabetes, some vitamins and not sure of the others. When asked how R2 was feeling, R2 indicated her mood was very good and did not feel sad or hopeless. When asked if staff had discussed any side effects the medications she was taking R2 indicated probably but would not remember. During interview on 2/5/15, at 8:50 a.m. LPN-B stated when a resident was first started on an antipsychotic, antidepressant or anti-anxiety medication, behavior monitoring and side effects are monitored each shift for one week and after that side effects are monitored by exception when and staff noticed any would write a nurses note and update the doctor immediately. R12's diagnoses included depressive disorder, anxiety, Alzheimer's, which were addressed on	21535		

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physician's orders dated 12/27/14. MDS dated 11/21/14 indicated R12 had severe cognitive impairment, no mood symptoms and received an antidepressant seven days a week. CAA's dated 2/18/14 indicated R12 had diagnoses for major depressive disorder, sundowners, anxiety, that she should be monitored for repetitive questions, obsessive concerns, sadness and teary eyed.

On 2/4/15, at 7:40 a.m. R12 was observed to ask the nurses if it was time for breakfast. R12 walked to the dining room, ate breakfast and at 8:03 a.m. R12 was sitting and reading a newspaper in the dayroom next to another resident on the couch. At 1:35 p.m. R12 was observed going to an activity with other residents to make valentine boxes.

R12's care plan dated 1/9/15, indicated R12 was at risk for side effects and /or adverse drug reactions related to depression and anxiety and the goal was to be at the lowest effective dose to control symptoms without any adverse side effects.

The current MAR dated 1/29/15-2/28/15, indicated R12 was receiving Effexor XR (anti-depressant) 150 mg oral (by mouth) once a day and Remeron (anti-depressant) 7.5 mg oral once a day starting 1/23/15 and increased to 15 mg on 2/5/15 once a day for major recurrent depressive disorder.

The quarterly assessment dated 12/15/14 indicated R12 was on "Effexor - 150 mg, d/c'd Klonopin (anti-anxiety medication) in October. Adverse effects."

Monthly Medication Regimen Review revealed the consultant pharmacist had reviewed R12's

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medications monthly, but had not indicated side effect monitoring was lacking for the antidepressant medications R12 was receiving.

During an interview on 2/5/15, at 8:51 a.m., the IDON stated that side effects are charted by exception and that when the physician visits she goes around and asks everyone if they noticed anything. IDON verified there was not side effect documentation.

R35 was observed on 2/5/15, at 8:18 a.m. in room, awake and dressed. When asked how she was today R35 stated "she didn't know yet." R35 walked down the hall toward dining room, stopped to talk to LPN-A and indicated she needed a haircut. LPN-A stated she would inform hairdresser today or she would assist R35 after breakfast. R35 walked into dining room and sat down at table.

Review of R35's Admission Record dated 12/30/14, indicated admission on 1/27/14, with diagnoses of Alzheimer's disease, and anxiety. R35's MDS dated 11/5/14, revealed moderate cognitive impairment. The care plan, dated 1/27/14, indicated "impaired cognition related to Alzheimer's dementia with severe cognitive impairment, to remain safe with meeting daily needs ongoing. On Aricept which was used for Alzheimer's disease. Care plan identified monitoring for behaviors of pacing, statements of anxiety, and agitation. Care plan identified fall risk related to Alzheimer's dementia with "episodes of wandering and inappropriate behavior."

Mahnomen Health Center quarterly dated 8/4/14, indicated "psychotropic medication review: care plan established Zoloft for anxiety, and Klonopin [an antianxiety medication] prn - used 4 times in

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21535	Continued From page 21 July." The Center for Psychiatric Care progress notes were reviewed from 9/24/14, going forward: 1. On 9/24/14, indicated "establish care and follow-up dementia and agitation. Mood generally good, anxiety, aggression, review of symptoms: depression, mania, mood, delusions, GAD [generalized anxiety disorder], dementia." 2. On 12/18/14, the note read, "Recheck mood/medication. Mood was good anxious, behaviors: agitation, medications: Zoloft, Aricept, Klonopin, review of symptoms: depression, GAD, and dementia. Medication changes: Increase Zoloft if anxiety continued to be problem, then can increase to 75 mg or can add Namenda [used to treat dementia associated with Alzheimer's disease], therapies per routine." 3. On 1/23/15, indicated "Mood good, no aggression, more wandering, boundary intrusive, review of symptoms: depression, GAD, dementia. Medication changes: consider Namenda for dementia/anxiety. Aricept is maxed, got side effect higher dose, could increase Zoloft if needed." Review of R35's Mahnomen Health Center Interdisciplinary progress notes from 11/17/14, going forward indicated the following: 1. On 11/15/14, indicated R35 had wandered during day in hallways and others rooms. 2. On 11/17/14, indicated R35 had gone into other resident's rooms. 3. On 11/29/14, indicated R35 had been removed from other resident's rooms. Review of the MAR for October, November and December 2014, January and February 2015, revealed daily target behavior monitoring for	21535		

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21535	Continued From page 22 "wandering outside or inappropriate areas, pacing, fidgeting, nervousness, agitation, crying, negative statements, signs or symptoms of depression." Monthly target behavior monitoring had been documented for day, afternoon, and night shifts. The signed Physician Order Report dated 12/1/14 through 12/31/14, indicated "Clonazepam (an anti-anxiety medication) 0.5 mg three times a day (TID) PRN for anxiety, Aricept (used for Alzheimer's disease) 10 mg once daily and Zoloft 50 mg once daily for anxiety." The CAA dated 2/5/15, indicated R35 received Aricept for dementia, needed supervision for safety and history of wandering, and had impaired cognition with Alzheimer's with episodes of wandering. On 2/5/15, at 10:10 a.m. the IDON stated was uncertain where side effects were being monitored and documented. On 2/5/15, at 12:08 p.m. via telephone the consultant pharmacist (CP) stated she would expect, when medication doses change, staff would monitor for side effects and effectiveness with quarterly changes. Problematic Behavior Management- Clinical Protocol revised 03/2013, directed "4. The nursing staff and the Physician will monitor for side effects and complications related to psychoactive medications; for example lethargy, abnormal involuntary movements ..." SUGGESTED METHOD OF CORRECTION: The director of nursing and or designee could	21535		

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21535	Continued From page 23 assure that policies and procedures are updated and staff training has been completed to assure each resident's drug regimen is monitored and that residents are not taking unnecessary drugs. An auditing tool could be developed to monitor compliance, with involvement of the facility's consultant pharmacist, to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty -one (21) days.	21535		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA.	21540		2/6/15

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21540	Continued From page 24 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility consultant pharmacist failed to identify medications irregularity regarding adequate monitoring for 4 of 5 residents (R7, R2, R12 and R35) who used antidepressants and antianxiety. In addition failed to consistently measure heart rate (pulse) and blood pressure as ordered by physician was monitored for 1 of 3 residents (R7) reviewed for unnecessary medications. Findings included: The facility did not monitor and obtain the needed pulse and blood pressure to ascertain if the medication was effective or not effective for R7. R7's Physician Order Report signed and dated 1/13/15, revealed R7 had the following orders for diagnosis of Atrial Fibrillation: Amiodarone 100 milligrams (mg) hold if systolic blood pressure (SBP) was less than 100 and Lopressor 12.5 mg Hold if SBP was less than 100 and pulse rate (PR) less than 60. R7's care plan dated 7/19/11, identified R7 had a diagnosis of hypertension and had prescribed antihypertensive medications daily. The care plan directed staff to give anti-hypertensive medications as ordered, monitor for increased heart rate, effectiveness and to obtain blood pressure readings under the same conditions each time. Medication Administration Records (MAR's) from September 2014, through February 2015, lacked documentation that blood pressures or pulse	21540	R7's perameters were discontinued due to MD's consideration for stable v.s on 2-12-15. Med passing staff educated on 2/6/15 to continue V.S parameters for medication until MD orders them D/C'd. Staff inservice on 2/24/15 on process. Plan added to existing Medication Administration policy and Antipsychotic Medication Policy amended. QI to monitor relation to parameters to EMar, with goal of 100% compliance to be reported to QI comm by Consulting Pharamacist. Pharmacist provided staff education on 2/12/15, non-pharm interventions to try before giving an antipsych medication, documenting the medication given if needed, outcome of the medication, proper documentation, dose reduction as an effort to reduce antipsyc meds. QI of nursing and Consulting Pharmacist to monitor unnecessary psych meds, reported to QI committe meeting with goal of 100% compliance. Side effects of antipsych,depressants and anxiety meds. Inservice completed by Consulting Pharmacist on 2/12/15 of side effects to watch for, document, report and med manage. List of meds' side effects placed on all medication carts. Staff meeting held to inform all staff of side effects to meds and reporting process to nursing 2/24/15. Medication Administration and Antipsychotic Medication Policies amended. QI monitoring will be conducted by nursing and Cunsulting Pharmacist and reported at QI committee meeting for	

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21540	Continued From page 25 readings had been done prior to medication administration. R7 was observed on 2/4/15 between 7:21 a.m. and 2:00 p.m. During this time, upon rising from bed, R7 ate breakfast in the dining room, attended activities in the television lounge and was assisted to the bathroom by NA-A. R7 was noted to doze off and on during the morning activities. At 2:00 p.m. R7 was observed lying in bed with eyes covered with a blanket. At 2:14 p.m. R7 was observed with eyes open and started to rub eyes. Interview with R7 at this time when asked if R7 was tired stated, "am always tired and sleepy all the time." On 2/4/15, at 8:43 a.m. licensed practical nurse (LPN)-A was interviewed and indicated she had already administered R7's medications. When asked what R7's blood pressure and pulse readings had been prior to administering medications LPN-A explained that R7's readings for blood pressure and pulse had been stable and that the vital signs were only done once a month and had not been done this morning. On 2/5/15, at 9:00 a.m. the interim director of nursing (IDON) verified R7's orders had directions for checking the blood pressure and pulse and acknowledged the vital signs were supposed to be checked prior to medication administration to assure they were within range. IDON verified that blood pressure and pulse had not been taken before administration of medications since September 2014. R7's Physician Order Report signed and dated 1/13/15, also revealed R7 had the following orders: Zoloft 100 mg once daily for depression	21540	100% compliance.	

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21540	Continued From page 26 and Lorazepam (Ativan) 0.5 mg once a day as needed (PRN) for anxiety. R7's quarterly, annual, interdisciplinary notes dated 6/1/14 through 2/5/15, lacked evidence of documentation for monitoring of side effects for Zoloft and lorazepam R7 received. R7's Psychotropic drug use Care Area Assessment (CAA) dated 4/3/14, identified R7 used Zoloft (antidepressant) and Ativan (lorazepam-anti-anxiety medication) as needed (PRN) and directed staff to use non-formulary interventions such as distraction, activities to distract R7 when complaining of eye problems prior to using Ativan. Psychotropic medication use care plan dated 7/19/11, identified R7 was at risk for side effects and/or adverse reactions due to daily use of antidepressant medication and use of as needed antianxiety medication. The care plan directed staff to administer medications as ordered, monitor and document side effects and effectiveness. Review of the MAR indicated R7 had received lorazepam, as needed dose, on 9/29/14, 1/29/15, and 1/31/15, and no non-pharmacological interventions prior to administering medication and effectiveness had been documented on 1/29/15, and 1/31/15. On 2/5/15, at 9:00 a.m. the interim director of nursing (IDON) , verified side effects monitoring for Zoloft and lorazepam were not being monitored and indicated these were only done by exception. IDON verified that on 1/29/15 and 1/31/15, when R7 had received the lorazepam no no-pharmacological interventions trialed prior to medication and effectiveness had been documented. IDON acknowledged the nurses	21540		

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21540	Continued From page 27 were supposed to document the interventions tried and do a follow up on the effectiveness of the medication. At 9:51 a.m. R7's primary physician was called but was not available. On 2/5/15, at 12:17 p.m. when asked what her expectation was of nurse with using non-pharmacological interventions prior to using Lorazepam as needed order, the CP stated via a telephone call she expected the nurses to document interventions behind a sheet in the MAR and the effectiveness of medication after administration. R2's diagnoses included depression, vascular dementia vascular, osteoporosis and cerebrovascular disease obtained from Resident Admission Record dated 12/29/14. R2's Physician Order Report dated and signed by the physician 1/13/15, indicated R2's had an order for Zoloft 75 mg by mouth once a day for depressive disorder. R2's annual Minimum Data Set (MDS) dated 12/25/14, indicated R2's had intact cognition, had no presence of mood symptoms and MDS indicated R2 received an antidepressant seven days a week. Care Area Assessment (CAA) for psychotropic medication use dated 1/19/15, identified R2 received an antidepressant and had increased fall risk as a result. R2's care plan dated 10/2/14, indicated R2 received an antidepressant Zoloft related to depression. The care plan directed staff to give antidepressant medications as ordered by physician, to monitor/document side effects and effectiveness and listed antidepressant side effects including dry mouth, dry eyes, constipation, urinary retention, suicidal ideation's.	21540		

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21540	Continued From page 28 On 2/4/15 at 7:40 a.m. R2 was observed lying in bed facing the window, with the television on. When interviewed, R2 indicated eating breakfast quick and not a lot because stomach was hurting and wanted to lay down for a little bit until dinner time. R2 was asked if familiar with the medications she was taking and stated she thought she received medications for heart, diabetes, some vitamins and not sure of the others. When asked how R2 was feeling, R2 indicated her mood was very good and did not feel sad or hopeless. When asked if staff had discussed any side effects the medications she was taking R2 indicated probably but would not remember. Review of the Annual MDS 3.0 Notes Report behavior note dated 1/12/15, indicated staff interviews had indicated R2 continued to have episodes of inappropriate use of the rest room but no side effect documentation was addressed. R2's Medication Administration Records (MAR's) from 8/1/14, through 2/5/15, it was lacked documentation of side effects monitoring. Pharmacist Medication Regimen Review monthly review revealed the consultant pharmacist (CP) had last completed on 1/20/15, and the CP had not identified the medical record lacked evidence of side effects monitoring. On 2/5/15, at 8:50 a.m. LPN-B stated when a resident was first week started on a antipsychotic, antidepressant or anti-anxiety medication, behavior monitoring and side effects are monitored each shift for one week and after that side effects are monitored by exception when the staff noticed any and would write a nurses note and update the doctor immediately.	21540		

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21540	Continued From page 29 R12's physician's orders dated 12/27/14 addressed diagnoses that included depressive disorder, anxiety, Alzheimer's. The MDS dated 11/21/14 indicated R12 had severe cognitive impairment, no mood symptoms and received an antidepressant seven days a week. CAA's dated 2/18/14 indicated R12 had diagnoses for major depressive disorder, sundowners, anxiety, that she should be monitored for repetitive questions, obsessive concerns, sadness and teary eyed. On 2/4/15, at 7:40 a.m. R12 was observed to ask the nurses if it was time for breakfast. R12 walked to the dining room, ate breakfast and at 8:03 a.m. R12 was sitting and reading a newspaper in the dayroom next to another resident on the couch. At 1:35 p.m. R12 was observed going to an activity with other residents to make valentine boxes. R12's care plan dated 1/9/15, indicated R12 was at risk for side effects and /or adverse drug reactions related to her depression and anxiety and the goal was to be at the lowest effective dose to control symptoms without any adverse side effects. The current MAR dated 1/29/15-2/28/15, indicated R12 was receiving Effexor XR (anti-depressants) 150 mg oral (by mouth) once a day and Remeron (anti-depressant) 7.5 mg oral once a day starting 1/23/15 and increased to 15 mg on 2/5/15 once a day for major recurrent depressive disorder. The quarterly assessment dated 12/15/14 indicated R12 was on "Effexor - 150 mg, d/c'd Klonopin (anti-anxiety medication) in October. Adverse effects."	21540		

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21540	Continued From page 30 Monthly Medication Regimen Review revealed the consultant pharmacist had reviewed R12's medications monthly, but had not indicated side effect monitoring was lacking for the antidepressant medications R12 was receiving. During an interview on 2/5/15, at 8:51 a.m., the IDON stated side effects are charted by exception and that when the physician visits she goes around and asks everyone if they notice danything. IDON verified they don't have side effect documentation. R35 was observed on 2/5/15, at 8:18 a.m. in room, awake and dressed. When asked how she was today R35 stated "she didn't know yet." R35 walked down hall toward dining room, stopped to talk to LPN-A and indicated needing a haircut. LPN-A stated would inform hairdresser today or would assist R35 after breakfast. R35 walked into dining room and sat down at table. Review of R35's Admission Record dated 12/30/14, indicated admission on 1/27/14, with diagnoses of Alzheimer's disease, and anxiety. R35's MDS dated 11/5/14, revealed moderate cognitive impairment. The care plan, dated 1/27/14, indicated "impaired cognition related to Alzheimer's dementia with severe cognitive impairment, to remain safe with meeting daily needs ongoing. On Aricept which was used for Alzheimer's disease. Care plan identified monitoring for behaviors of pacing, statements of anxiety, and agitation. Care plan identified fall risk related to Alzheimer's dementia with "episodes of wandering and inappropriate behavior." The Center for Psychiatric Care progress notes	21540		

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were reviewed from 9/24/14, going forward and the following was noted:
1. On 9/24/14, indicated "establish care and follow-up dementia and agitation. Mood generally good, anxiety, aggression, review of symptoms: depression, mania, mood, delusions, GAD [generalized anxiety disorder], dementia."

2. On 12/18/14, the note read, "Recheck mood/medication. Mood was good-anxious, behaviors: agitation, medications: Zoloft, Aricept, Klonopin, review of symptoms: depression, GAD, and dementia. Medication changes: Increase Zoloft if anxiety continued to be problem, then can increase to 75 mg or can add Namenda [used to treat dementia associated with Alzheimer's disease], therapies per routine."

3. On 1/23/15, indicated "Mood good, no aggression, more wandering, boundary intrusive, review of symptoms: depression, GAD, dementia. Medication changes: consider Namenda for dementia/anxiety. Aricept is maxed, got side effect higher dose, could increase Zoloft if needed."

Review of R35's Mahnomen Health Center Interdisciplinary progress notes from 11/17/14, going forward indicated the following:
1. On 11/15/14, indicated R35 had wandered during day in hallways and others rooms.
2. On 11/17/14, indicated R35 had gone into other resident's rooms.
3. On 11/29/14, indicated R35 had been removed from other resident's rooms.

Review of the MAR for October, November and December 2014, January and February 2015, revealed daily target behavior monitoring for "wandering outside or inappropriate areas,

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pacing, fidgeting, nervousness, agitation, crying, negative statements, signs or symptoms of depression." Monthly target behavior monitoring had been documented for day, afternoon, and night shifts.

Signed Physician Order Report dated 12/1/14 through 12/31/14, indicated "Clonazepam (an anti-anxiety medication) 0.5 mg three times a day (TID) PRN for anxiety, Aricept (used for Alzheimer's disease) 10 mg once daily and Zoloft 50 mg once daily for anxiety."

The CAA dated 2/5/15, indicated R35 received Aricept for dementia, needed supervision for safety and history of wandering, and had impaired cognition with Alzheimer's with episodes of wandering.

During review of the Pharmacist's Drug Regimen Review it was revealed the consultant pharmacist had completed the last monthly review on 1/20/15, and side effect monitoring for psychotic medications R35 was receiving on a daily basis were not being monitored.

On 2/5/15, at 10:10 a.m. the IDON stated was uncertain where side effects were being monitored and documented.

On 2/5/15, at 12:08 p.m. via telephone the consultant pharmacist (CP) stated she would expect when medication doses change staff was monitoring for side effects and effectiveness with quarterly changes.

Problematic Behavior Management- Clinical Protocol revised 03/2013, directed "4. The nursing staff and the Physician will monitor for side effects and complications related to

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21540	Continued From page 33 psychoactive medications; for example lethargy, abnormal involuntary movements ..." SUGGESTED METHOD OF CORRECTION: The director of nursing and or designee could assure that policies and procedures are updated and that staff training has been completed to assure each resident's drug regimen is monitored and that residents are not taking unnecessary drugs. An auditing tool could be developed to monitor compliance, with involvement of the facility's consultant pharmacist, to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty -one (21) days.	21540		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure grab bars on resident beds, used for positioning/transfers, were maintained to assure stability for 6 of 6 residents (R32, R23, R14, R33, R37, R5) observed with grab bars. Finding include: R32's room observation was conducted on	21685	All rooms were screened by Maintenance staff and all grab bars were secured by 2/5/15. Staff educated to report any equipment concerns to RN or Maintence immediately upon observation at staff meeting on 2/24/15. Maintenance staff educated on 2/6/15. Policy developed to ensure safe operation and maintenance	2/5/15

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21685	Continued From page 34 2/3/15, at 1:52 p.m. and a grab bar on the bed was observed to be loose and wiggled back and forth when checked. R32's Care Area Assessment (CAA) dated 9/26/14, indicated an evalution for grab bars had been done and grab bars had been placed on bed following a fall that R32 had slid out of bed five days after admission. R23's room observation was conducted on 2/3/15, at 11:37 a.m. and two grab bars attached to R23's bed were observed to be loose and wiggled when checked. R23's Quarterly MDS, dated 10/4/14, indicated R23 had not had any falls and the self care deficit care plan, dated 1/13/15, directed staff to assist turning R23 using grab bars. R14's room observation was conducted on 2/3/15, at 1:52 p.m. and the covered left side grab bar attached to R14's bed was noted to be loose and wiggled approximately one inch, when checked. During interview, R14 was asked if the grab bar was used and R14, stated "its strong enough, I use it to get up." R14's activities of daily living (ADL's) care plan dated 7/18/13, directed staff for R14's bed mobility to utilize the grab bar on the left side of bed to help with positioning. R33's room observation was conducted on 2/3/15, at 1:50 p.m. and the right grab bar attached to R33's bed was observed to be loose and moved back and forth approximately one inch when checked. When asked, R33 indicated using the grab bar for turning self in bed. R33's care plan dated 8/22/13, directed staff for bed mobility R33 was able to turn self once in bed. On 2/4/15, at 2:35 p.m. an environmental tour was	21685	plan for resident-related equipment, to include both scheduled in-room assessment by maintenance staff and reporting process for clinical staff. QI indicator to monitor for 100% compliance of plan.	

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21685	Continued From page 35 conducted with the facility director of maintenance (MD) and the loose grab bar attached to R33's bed was looked at. Interview with R33, regarding the loose grab bar, R33 explained, "I just got used to it that way. When I was in the other room it was tighter for a couple days then it got loose." R37's room observation was conducted on 2/3/15, at 11:25 a.m. and the right grab bar attached to R37's bed was noted to be loose and wiggled when checked. R37's ADL functional/rehabilitation care plan dated 12/13/14, identified R37 was able to use grab bars to help turn side to side. R5's room observation was conducted on 2/3/15, at 1:56 p.m. and both grab bars attached to R5's bed were observed to be loose and wiggled when checked. R5's care plan dated 6/25/13, identified R5 required extensive assist of one staff and would roll side to side with cues. On 2/3/15, at approximately 9:47 a.m., during an interview with MD stated all grab bars in residents rooms were applied to the bed with a therapy recommendation and indicated his department applied the grab bars to the bed. When asked who made sure the grab bars were stable, MD stated therapy would follow up to make sure the grab bars were appropriate. On 2/4/15, at 2:35 p.m., during the environmental tour with MD, it was verified the grab bars were loose/wiggled when checked. MD stated this was how the grab bars came from the manufacture and showed surveyor the grab bars were secured with a removable pin that went through the grab bar at the bottom, which when removed the grab bar was able to fold inward. During the tour when	21685		

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	00353	A. BUILDING: _____ B. WING _____	02/05/2015

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21685	Continued From page 36	21685		

reviewing R5's grab bars attached to the bed it was noted the grab bar by the window was tight and MD verified the grab bar was stable and tight compared to the other grab bars reviewed prior to it. Upon looking at the bolt located on top of the removable pin, MD indicated it appeared to have more thread visible and retrieved a screw driver to attempt to tighten it. At 2:45 p.m. after turning the bolt a few times MD was able to tighten the grab bar to assure stability.

At 3:05 p.m. occupational therapy (OT) verified the grab bars in R14's bed were loose. When asked if this is how the grab bars were meant to be, OT indicated the grab bars were applied to the beds to assist the resident with bed mobility and not transfers. OT indicated the grab bar moved back and forth approximately one inch. Both OT and MD acknowledged the grab bars should be stable if residents used them to assist with transfers.

When asked who was responsible to ensure the grab bars were tight and stable OT and MD indicated this was something the facility had not assigned to a specific department.

SUGGESTED METHOD OF CORRECTION: The director of facility operations or his designee could develop a system to ensure the environment the physical plant, including systems and equipment must be kept in a continuous state of good repair and operation with regard to safety. The director of facility operations or his designee could develop a system for staff to report any concerns with the physical plant. All facility staff could be educated on these systems. The director of facility operations or his designee could develop a monitoring system to ensure

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21685	Continued From page 37 ongoing compliance. Time Period for Correction: Forty (40) days.	21685		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to attempt to form a family council within the past calendar year as required. This had the potential to affect all 26 residents who resided in the facility. Findings include: On 2/3/15, 12:07 p.m. licensed social worker (LSW) provided a white three ring binder titled Mahnomen Health Center [MHC] Family Council which inside she showed an agenda for 6/13/13, when she indicated the last meeting had been held. LSW indicated she had started working at the facility in the December 2014 and as far as	21942	Social Services and Nursing Home Staff were educated on 2/24/2015 of the need for a Family Council and if dissolved due to lack if interest or members, documentation needs to occur when an annual attempt has been made to reactivate the desire for a Family Coucil. Various attempts will be made to try to stimulate the interest for the Family Council. Letters will be sent to all family members on 3/4/15, to inquire about interest, an invitation for a Family Counsil session to be determined, and to provide MHC contact. Policy in place. QI indicator owned by Social Services to ensure annual compliance with an active	2/24/15

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21942	Continued From page 38 she was aware this was the last time family council may have been held per the records in the binder. LSW further stated she was in the process of putting something together to attempt to revive the family council as it was facility policy to attempt to form a family council each year. On 2/5/15, at 11:16 a.m. the chief executive officer/administrator acknowledged the facility had not attempted to form a family council as directed by the facility policy within the last year. The Mahnomen Health Center Family Council Purpose directed "It is the purpose of the Mahnomen Health Center Family Council to reach out new residents and families ..." The family council purpose did not indicated who was responsible for attempted to form the family council each calendar year and who was responsible to oversee an attempt was made. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review or revise policies, provide education for staff regarding formulation of a Family Council. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21942	Family Council, or an attempt to reinstate it.	