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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PE4L

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00049

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245491**

2.STATE VENDOR OR MEDICAID NO.
(L2) **857637200**

3. NAME AND ADDRESS OF FACILITY
(L3) **AUGUSTANA MERCY CARE CENTER**
(L4) **710 SOUTH KENWOOD AVENUE**
(L5) **MOOSE LAKE, MN** (L6) **55767**

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) **09/01/2010**

6. DATE OF SURVEY **06/09/2016** (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 **72** (L18)

13.Total Certified Beds **72** (L17)

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	72			
(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 :
Kathie Killoran, HFE NEII 06/30/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 08/19/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
05/24/2016 (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245491

July 26, 2016

Ms. Tara Peterson, Administrator
Augustana Mercy Care Center
710 South Kenwood Avenue
Moose Lake, Minnesota 55767

Dear Ms. Peterson:

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 May 24, 2016 the above facility is certified for:

72 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 72 skilled nursing facility beds.

Please advise iff 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.

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
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 17, 2016

Ms. Kim Tyson, Administrator
Augustana Mercy Care Center
710 South Kenwood Avenue
Moose Lake, MN 55767

RE: Project Number S5491025

Dear Ms. Tyson:

On April 28, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 14, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On June 9, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on May 27, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 14, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 24, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 14, 2016, effective May 24, 2016 and therefore remedies outlined in our letter to you dated April 28, 2016, 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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245491 Y1	A. Building B. Wing Y2	6/9/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA MERCY CARE CENTER	710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0154	Correction	ID Prefix F0241	Correction	ID Prefix F0258	Correction
Reg. # 483.10(b)(3), 483.10(d)(2)	Completed	Reg. # 483.15(a)	Completed	Reg. # 483.15(h)(7)	Completed
LSC	05/11/2016	LSC	05/16/2016	LSC	05/24/2016
ID Prefix F0465	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.70(h)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	05/24/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TA/kfd	6/17/2016	29625	6/9/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
4/14/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245491 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	5/27/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA MERCY CARE CENTER	710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0017	05/15/2016	LSC K0029	05/24/2016	LSC K0051	04/28/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0052	04/18/2016	LSC K0056	05/24/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	6/17/2016	27200	5/27/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
4/12/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

June 17, 2016

Ms. Kim Tyson, Administrator
Augustana Mercy Care Center
710 South Kenwood Avenue
Moose Lake, MN 55767

Re: Reinspection Results - Project Number S5491025

Dear Ms. Tyson:

On June 9, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 9, 2016. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00049 Y1	A. Building B. Wing Y2	6/9/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA MERCY CARE CENTER	710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	20555	Correction	ID Prefix	21426	Correction	ID Prefix	21665	Correction
Reg. #	MN Rule 4658.0405 Subp. 1	Completed	Reg. #	MN St. Statute 144A.04 Subd. 3	Completed	Reg. #	MN Rule 4658.1400	Completed
LSC		05/11/2016	LSC		04/25/2016	LSC		05/24/2016
ID Prefix	21805	Correction	ID Prefix	21860	Correction	ID Prefix		Correction
Reg. #	MN St. Statute 144.651 Subd. 5	Completed	Reg. #	MN St. Statute 144.651 Subd. 16	Completed	Reg. #		Completed
LSC		05/11/2016	LSC		05/11/2016	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	TA/mm	06/17/2016	29625	06/09/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
4/14/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: PE4L

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00049

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245491**

2.STATE VENDOR OR MEDICAID NO.
(L2) **857637200**

3. NAME AND ADDRESS OF FACILITY
(L3) **AUGUSTANA MERCY CARE CENTER**
(L4) **710 SOUTH KENWOOD AVENUE**
(L5) **MOOSE LAKE, MN** (L6) **55767**

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) **09/01/2010**

6. DATE OF SURVEY **04/14/2016** (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 **72** (L18)

13.Total Certified Beds **72** (L17)

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	72			
(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 :
Kathie Killoran, HFE NE II — 05/12/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 05/18/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 28, 2016

Ms. Kim Tyson, Administrator
Augustana Mercy Care Center
710 South Kenwood Avenue
Moose Lake, Minnesota 55767

RE: Project Number S5491025

Dear Ms. Tyson:

On April 14, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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:

Minnesota Department of Health
Telephone:
Fax:

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 May 24, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

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

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 July 14, 2016 (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 October 14, 2016 (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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012
Fax: (651) 215-0525

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

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: 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
	245491	A. BUILDING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA MERCY CARE CENTER	710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767

(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 154 SS=D	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that 1 of 1 residents (R134) received health information in a manner that was understandable and provided at a time that was most useful to the resident. Findings include	F 154	F154; It is the policy of Augustana Mercy Health Care Center to fully inform residents in advance about changes on their care and treatment. An initial care conference was held with resident R134 on 4/15/16 she reported that she was in agreement with her plan of care and had no further concerns. On 4/15/16 facility	5/11/16

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

Electronically Signed | 05/05/2016

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

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F 154	Continued From page 1 R134's face sheet identified diagnoses that included cervical radiculopathy (damage to nerve due to compression in the cervical vertebra), arthrodesis (fusion) of the cervical vertebra, anxiety and depression. According to R134's progress notes, she was cognitively intact and able to make her own health care decisions. In an interview on 4/13/16, at 9:57 a.m., family member (FM)-B stated when R134 was admitted to the facility, they felt the paperwork was incorrect. FM-B said they asked registered nurse (RN)-G if they could see the interagency referral and they were refused. According to FM-B (RN-G was unavailable during the survey), RN-G told them once an interagency referral is in their hands it is the facility's property. FM-B stated they had questions about R134's medications, amount of assistance recommended, and if R134 could shower. FM-B did not feel that the facility answered their questions in a timely manner or in a manner that R134 could understand. FM-B also stated it was a good thing he was there, as he provided all cares for R134 during the first few days she was in the facility. In an interview on 4/14/16, at 1:53 p.m., the director of nursing (DON) stated RN-G usually talked to families or residents upon admission. The DON stated residents can look at anything in their medical record, usually the same day or the next day. The DON clarified the facility usually had a nurse sit with them to interpret the medical content. If a resident or their power of attorney wants a copy, the facility has a standard consent	F 154	social worker met with resident R134 and provided her with the medical records consent form the resident was provided with instructions on how to request copies of her medical record. All facility staff were re- educated on 4 /21/16 on procedure for addressing concerns and medical records requests in the event a resident requests their medical records. All staff that assist in care and treatment plans will be educated on the need to fully inform residents in advance about any changes on their care and treatment. At Care Conferences the resident/responsible party will be asked if they have been informed in advance about changes to their care and if the explanation was understandable. During the initial care conference for all new residents the IDT team will review the care plan with the resident and or responsible party and ensure they are able to understand the information presented. The RN manager assigned to the resident will also review the care plan with the resident and or responsible party by day 21 to ensure they understand. The DON or designee will complete five random audits per week for 4 weeks and then five per month for 3 months to ensure compliance. All results will be reviewed by the facility quality assurance committee to determine further compliance needs. Corrected by 5/11/16	

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F 154	Continued From page 2 form to sign. In an interview on 4/14/16, at 1:59 p.m. R134 stated she was admitted on a Monday and it was a rough start. R134 stated they were greeted by RN-G and gave her the referral packet from the hospital. R134 stated she had surgery on her neck and she was a registered nurse. R134 stated later on in the day she was admitted, or the next day, she asked about her instructions, appointments, restrictions, assistance needed, basically what the "game plan was". R134 stated she asked to see the interagency packet or get a copy of it. R134 said it was very awkward because they were in a public area and she was told no. R134 said she knows it was her right to see her health information, and said so at the time. According to R134, the unidentified staff person asked her "what exactly are you asking for?". R134 reported she replied, she just had a lot of questions. The staff person then told her, "they would have to check on that." R134 said RN-B did come in another day after that and go through the chart with her, however, R134 said she had questions and didn't feel that they were answered by RN-B, even at that time. Questions such as: Why isn't a gait belt being used? Am I supposed to use a wheelchair or a walker? Am I supposed to have assistance when I transfer?. R134 continued to state the chart was held at lap level, so with her neck brace on, it was hard to see the chart and she felt that she couldn't truly review it. R134 also stated when she received her medications she did not recognize them all and asked the unidentified staff person what "the little	F 154		

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F 154	Continued From page 3	F 154		

white pill" was. The staff person replied that they did not know and would have to check on it. R134 said it was "freaky" to take pills from someone who didn't know what they were. R134 said they told her later that it was just Pepcid (for stomach acid). To further her frustration, staff couldn't tell R134 when they were prescribed or why.

R134 said she had a swallow study and was told not to take pills without them being crushed. However, sometimes she was getting pill crushed, and other times not.

R134 said there was a discrepancy between the interagency paperwork and the implementation of assistance in the facility. R134 stated she was transferring herself and had been throughout her stay, but she never knew what the recommendations was from the hospital.

In an interview on 4/14/16, at 2:19 p.m., RN-B stated there were discrepancies in the paperwork received from the referring hospital. RN-B stated she had to call the referring hospital and clinic many times to get the correct orders.

RN-B stated she did bring R134's chart to her room and review it with her. However, RN-B stated she told FM-B that they would have to call the referring hospital for a copy of the Interagency Referral Form.

RN-B stated R134 was self-transferring at the time of admission and the paperwork indicated R134 was an assist of 1 with front wheeled walker.

In an interview on 4/14/16, at 2:42 p.m., R134

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F 154	Continued From page 4 stated she asked a staff person if there was a shower nearby, as she hadn't been asked about a bath or shower. R134 reported she was told "no", with no other information. A day or so later someone told her bath days are Tuesdays. R134 wondered why someone couldn't have said, "I don't know, but let me find out and I'll let you know; or, would you like to have a shower today?" R134 said the staff, including the therapists, didn't seem to know what the plan was for her, and everyone kept asking her the "game plan", but she had no idea. R134 said even though they are planning a care conference, she did not feel involved in her care.	F 154		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a dignified dining experience in 1 of 2 resident dining rooms. In addition, the facility failed to ensure dignity was maintained during personal cares for 1 of 3 residents (R12) reviewed for dignity. Findings include: During a dining observation on 4/11/16, from 5:40 p.m. until 6:26 p.m., residents were seated at 11	F 241	F241;It is the policy of Augustana Mercy Health care center to ensure that dignity is provided for all residents at all times. All facility staff were provided education on 4/21/16 regarding dignity during dinning and with personal cares in regards to language and privacy. All nursing staff were provided education regarding need to excuse visitors from rooms when placing a resident on the commode. ADON met with resident R12 and her daughter on 5/10/16 and private room	5/16/16

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F 241	Continued From page 5 tables in the facility dining room. In addition to a room full of residents, 3 family members were at tables visiting. Approximately half of the residents had been served dinner, and the others were sitting with beverages. By 6:11 p.m., approximately half of the residents had been served their meal and staff were continuing to bring food out for the residents. At 6:13 p.m., nursing assistant (NA)-A, was walking between dining room tables to the kitchen and stated to a staff person following behind her, "We don't feed the feeders until last." Several tables of residents, including residents who needed assistance with their meal, were within earshot of this statement. In an interview on 4/11/16, at 6:20 p.m., NA-A again stated they feed "feeders" last. NA-A confirmed she had used that word to describe residents who needed assistance with eating. NA-A agreed it may not be a respectful reference for a person. In an interview on 4/14/16, at 1:43 p.m., the director of nursing (DON) stated she would expect staff not to use the term "feeder" in reference to residents. The DON stated they, "don't want staff to be saying that." R12 felt bad when chided for her frequent need to use the commode. R12 used a commode just behind a curtain and at times her roommate had visitors. In addition, staff would open R12's window while she was on the commode so they can have "fresh air". R12's face sheet indicated diagnoses which included frequency of micturition (frequent need	F 241	was offered to resident. Resident and daughter agreeable to private room and resident moved on 5/11/16. No other resident's in the facility use a commode and have a roommate at this time. In the future RN staff will address need for commode use in a shared room in their bowel and bladder assessments that are completed upon admission, quarterly and with significant change. Staff will take steps such as asking visitors to exit the room while the commode is being use, ensure the privacy curtain is closed, and consider private room arrangements. If it is identified through the assessment that a resident needs to use a commode while residing in a shared room the DON or ADON will be notified and alternative options will be reviewed such as a private room if necessary. All bowel and bladder assessments will be reviewed to ensure that there are no further privacy issues in regards to toileting. To ensure compliance; the Dietary Director or designee will complete five random dining room audits weekly for 4 weeks then five monthly for 3 months to ensure compliance with results being reviewed by the quality assurance committee to determine further compliance needs. The DON or designee will complete five random audits of personal cares provided by staff weekly for x 4 weeks then five monthly for 3 months with the results being reviewed by quality assurance committee to determine further compliance needs. Corrected by 5/16/16	

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F 241	Continued From page 6 to urinate), edema, muscle weakness and chronic kidney disease. R12's Physician Order Report, dated 4/14/16, indicated R12 received 40 milligrams (mg) of Lasix, a diuretic, twice a day, at 8:00 a.m. and 12:00 noon. R12's quarterly Minimum Data Set (MDS), dated 2/16/16, indicated R12 had moderate impairments in cognition, was always continent of bladder and bowel, and had no signs of delirium or behaviors. R12's toileting care plan, dated 2/22/16, indicated R12 was to be toileted every two hours and prior to 11:30 a.m. (lunch). The goal indicated to have R12 maintain bladder continence on the day shift. In an interview on 4/11/16, at 4:04 p.m., R12 stated staff don't always treat her with respect and dignity. R12 stated she waited and waited for staff to answer her call light, and when she had to go, she had to go. R12 continued to explain the staff would come to the door, turn off the call light and say they would return in a few minutes, but they didn't return. R12 said she would have to put her call light on again. In an observation on 4/13/16, beginning at 12:57 p.m., R12 and her roommate were in their room. The roommate had a male visitor. R12's call light came on and two staff responded with a Hoyer lift at 12:59 p.m. At 1:09 p.m., R12's light came back on. At 1:17 p.m., two aides entered the room and shut the door. At 1:21 p.m., R12's roommate and visitor exited the room and went to the day room. At 1:24 p.m., R12 was sitting in her room, in her wheelchair reading a book.	F 241		

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F 241	Continued From page 7 In an interview on 4/13/16, at 1:32 p.m., nursing assistant (NA)-F stated R12 used a commode in the bedroom because she needed a Hoyer lift for transfers and there was not enough room to move around the roommate into the bathroom. NA-F showed her group sheet where she had indicated R12's use of the commode at 1:16 p.m. In a telephone interview on 4/14/16, at 10:13 a.m., family member (A) stated they have been told that they can't get the Hoyer lift into the bathroom so R12 used a commode in the bedroom. FM-A stated it's an issue of using the commode when R12's roommate has company. FM-A stated R12 has to sit behind the curtain and the staff don't ask the roommate's company to leave. FM-A stated the staff will at times, open the window for "fresh air" while R12 used the commode. FM-A also stated when staff did that, air blew right on R12 while she is sitting on the commode. FM-A stated they have brought up the use of the commode and the cleanliness of the commode at care conferences. FM-A stated the cleanliness of the commode was addressed, but not the privacy and dignity issues. FM-A also stated R12 has frequent urges to urinate and she worried about "wetting herself". FM-A had observed the staff answer R12's light and say, "You just went". FM-A wondered if there was a limit on the number of times a resident can use the commode. In an interview on 4/14/16, at 11:04 a.m., R12 stated that while the curtain did get pulled, residents should have a little more privacy. R12 stated she lost her bathroom privileges, now that she needed the lift, but she "can't help it." R12	F 241		

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F 241	Continued From page 8 also stated staff told her she's not the only one and they're "so snotty". In an interview on 4/14/16, at 11:42 a.m., registered nurse (RN)-A stated she hoped that staff would ask the visitor to step out of a room while a resident is using the commode. RN-A reiterated that staff should ask family and visitors to step out for a few minutes. RN-A stated it was a dignity issue for residents. RN-A continued she got frustrated with staff who were frustrated with residents who have urge issues. RN-A stated she educated staff that you can t make someone "go less", you have to assist them. RN-A stated she explained to staff that an urge to urinate is not a behavior and they can't tell a resident they can't go. Policies on privacy and dignity were requested but not received.	F 241		
F 258 SS=D	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure comfortable sound levels for 1 of 3 residents (R12) reviewed for dignity. Findings include: R12's face sheet indicated diagnoses which	F 258	F258; It is the policy of Augustana Mercy Health Care Center to ensure comfortable sound levels for all residents. The resident and daughter were interviewed again on 5/10/16 and offered private room. Resident and daughter agreed to room change. Resident moved to private room	5/24/16

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F 258	Continued From page 9 included frequency of micturition (frequent need to urinate), muscle weakness and chronic kidney disease. R12's quarterly Minimum Data Set (MDS), dated 2/16/16, indicated R12 had moderate impairments in cognition, adequate hearing, did not use hearing aids, and had no signs of delirium or behaviors. R34's quarterly MDS dated 2/27/16, indicated R34 was cognitively intact and had minimal difficulty with hearing when used hearing aids. The MDS indicated admission to the facility was in 11/13. In addition, the MDS indicated R34 exhibited verbal behavior symptoms directed toward others (threatening, screaming, or cursing at others). The MDS indicated R34 had mild symptoms of depression. During an observation on 4/11/16, at 4:44 p.m., R34's TV was noted to be on very loud. During an observation on 4/13/16, at 7:34 a.m., R34's TV was on. During an observation on 4/13/16 at 8:38 a.m., R34's TV was on and could be heard in the hallway. During an observation on 4/14/16, at 9:45 a.m., R34's TV was on and loud; R34 was dozing in her wheelchair. During an observation on 4/14/16, at 11:36 a.m., R34's TV could be clearly heard two rooms away. Review of R12's care conference notes indicate R12 raised a concern about the volume of R34's	F 258	5/11/16. All facility staff will be educated on need to ensure comfortable sound levels and to report resident concerns about sound levels as soon as they occur. All interviewable residents will be questioned to ensure that there are no complaints about sound levels. All residents and or their responsible parties will be provided with a letter that outlines the process for reporting concerns in the building including those that involve noise. A committee to focus on noise reduction will be developed to identify the status of noise levels and identify opportunities for improvement. Upon admission the resident/responsible party will be provide a copy of the handbook and the concern process. The Concern Policy was reviewed on 4/22/16 and found to be current. All facility staff including front line staff were re-educated on 4/21/16 about the process for reporting resident concerns including reporting roommate concerns with noise. Staff were educated if a resident has a TV or other electronic devices is noted to be too loud, clearly audible from the hallway they can request the device to be turned, assist the resident in turning it down to a comfortable level and then report the concern to a supervisor immediately. The facility will provide head phones for residents who need to or wish to listen to electronic devices at excessive volumes. The facility will also make ear plugs available upon request. All concerns including those regarding sound levels will be addressed per policy as soon as they are reported and or identified by staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245491	A. BUILDING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA MERCY CARE CENTER	710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767

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F 258	Continued From page 10 TV at a care conference on 9/8/15 and 3/10/15. Notes from the 9/8/15 conference read, "Resident encouraged to update staff so staff can assist with lowering the TV volume and roommate to turn down TV by 10 p.m." During an interview on 4/11/16, at 4:04 p.m., R12 stated R34's TV goes "day and night". R12 stated sometimes R34 turned it off by 10:00 p.m. R12 continued to state she knew she went to bed too early. R12 stated everything went the way R34 wanted it, and "that's it". R12 stated when she asked R34 to turn down the volume the roommate would reply, "I can't". R12 stated the loud TV drove her nuts. She said she had a TV, but she doesn ' t' t even turn it on anymore. R12 said she used to enjoy watching TV, but doesn't anymore. R12 said she has told staff, but they tell her there isn't anything they can do about it. In an interview on 4/14/16, at 10:13 a.m., family member (FM)-A stated R12 has had an issue with the TV volume since R34 moved in a couple of years ago. FM-A stated they go to every care conference, they complain about the TV volume in between times and occasionally the TV gets turned down but mostly nothing was done. The last time FM-A brought it up, she was told it was R34's right to have the TV on loud and if R12 had a problem with it she could move to a different room. FM-A stated the TV was an ongoing issue and made R12 cry, which made FM-A cry. FM-A stated sometimes the TV was so loud they couldn't talk; they usually left the room in order to visit. FM-A stated they suggested headphones, but	F 258	along with, additional follow up at Care Conferences the resident/responsible party will be asked if there are any concerns that the resident may have. Concerns will be addressed per policy. The DON or designee will complete five random audits per week of sound levels for 4 weeks and then five per month for 3 months to ensure compliance. All results will be reviewed by the facility quality assurance committee to determine further compliance needs. Corrected by 5/24/16	

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F 258	Continued From page 11 R34 refused. FM-A stated they felt there was nothing they could do. FM-A stated it was very hard to watch R12 cry, at her age. FM-A stated sometimes the staff are flip about R12's concern and they would even turn on R34's TV in the morning in order to catch the morning shows. In an interview on 4/14/16, at 11:04 a.m., R12 stated there's, "nothing I can do about it". R12 said R34 sat and slept all day with the TV blaring. R12 indicated it was her own fault because she went to bed so early. R12 stated she's not happy, but she shouldn't grumble. R12 pulled out a handkerchief, and wiping tears from her eyes said, "I wish it were different, but I can't do anything about it so I better make up my mind I'm going to like it." R12 ended by saying, "I've always gotten along with everybody, but not anymore." In an interview on 4/14/16, at 11:51 a.m., the social worker (SW)-A confirmed R34 had her TV on all day and often very loud. SW-A stated it was a resident's right to have the TV on at their level. SW-A stated some residents use headphones to accommodate roommates, but some residents are not willing to do that. SW-A said they talked about it, but "there's not much we can do about it." SW-A stated R34 has refused headphones and R12 won't move from the room. SW-A stated she would turn down the TV when walking by and they encouraged aides to do the same (when the roommate is sleeping). However, SW-A also stated R34 was completely oriented and knew her right to have the TV on. SW-A stated they had not talked to the ombudsman about a solution.	F 258		

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F 465	Continued From page 12	F 465		
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: Based on observation, interview, and document review, the facility failed to ensure collection of unconsumed food items on meal trays which did not provide a clean and pleasant room environment for 1 of 3 residents (R106) reviewed for nutrition. In addition, the facility failed to ensure ensure walls, doors, and floors were properly maintained to provide a cleanable and home-like environment in 8 of 30 resident rooms (201, 205, 308, 310, 312, 315, 317, and 407) reviewed for environment. Findings include: On 4/12/16, at 2:01 p.m. a meal tray was observed on a table located to the right of R106's bed. The meal tray had a plate with a plastic dome which covered unconsumed foods including: a scrambled egg, two pieces of bacon and toast. Upon entering R106's room there was an obvious, foul odor. R106 reported the meal tray was delivered to her room on 4/12/16 around 7:00 a.m., (7 hours earlier). R106 reported staff forgot to come back to the room to pick up the food, then stated, the breakfast food on the tray had made a very unpleasant smell in the room all day.	F 465	F465 It is the policy of Augustana Mercy Health Care Center to ensure a clean and pleasant environment in the facility. Meal tray was removed from resident R106 as soon as the error was noted. All staff will be educated on importance of picking up meal trays within two hours of the meal served. A new procedure for tracking room trays being delivered and picked up will be implemented. The DON or a designee will audit room tray pass on 5 residents per week for 4 weeks and then 5 residents per month for 3 months with results being reported to Quality assurance committee to determine further compliance needs. Staff education was provided on 4/21/16 regarding need to report all maintenance concerns in rooms as soon as they are noted. Maintenance staff has made all necessary repairs to the rooms outlined in the 2567 report. Audits will be made of all resident rooms and repairs will be completed. 10 room maintenance audits will be completed monthly with Maintenance Director and reported to QA Administrator for review. Corrected by 5/24/15	5/24/16

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F 465	Continued From page 13 On 4/12/16, at 2:28 p.m. a staff member was observed collecting lunch trays from other resident rooms, R106's breakfast tray remained in the room on the table. On 4/12/16, at 2:44 p.m. nursing assistant (NA)-A reported the nursing assistants are to pass and pick up the meal trays for those residents that wish to eat in their room, then document intakes. NA-A reported she was unsure which staff member delivered the breakfast tray to R106. Upon request, NA-A removed the meal tray from R106's room. NA-A lifted the plastic dome off of the plate to identify the food items and stated, "oh that stinks." NA-A confirmed the eggs, bacon and toast were served in the morning and should have been picked up after breakfast. On 4/12/16, at 2:47 p.m. licensed practical nurse (LPN)-A reported the nursing assistants were to pass and pick up all meal trays. If for some reason the staff could not complete the task they would communicate that to the nurses. LPN-A stated that was not the case today, and confirmed she worked the unit in which R106 resided. LPN-A stated R106's breakfast tray was delivered on 4/12/16 around 8:00 a.m., and was not removed until requested at 2:44 p.m.. Review of the Augustana Mercy Care Center Dining Menu Dated 4/12/16, identified breakfast was a cheese omelette, bacon, wheat toast. On 4/13/16, at 8:00 a.m. R106 was observed to ambulate independently to the dining room. R106 was able to eat and drink independently. On 4/13/16, at 8:40 a.m. R106 was resting on the bed, a plate with a plastic dome rested on a table	F 465		

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F 465	Continued From page 14 next to R106's bed. There was unconsumed food on the plate which included french toast and a hash brown triangle. R106 reported the food on the plate, the french toast and hash brown triangle was brought in last night for supper and had been there ever since. R106 stated staff never came to get it, then "I guess the staff think I am invisible in here." On 4/13/16, at 8:59 a.m. upon request, registered nurse (RN)-A removed the meal tray from R106's room. RN-A confirmed the french toast and hash brown triangle were served the previous day for supper (15 hours earlier). RN-A further stated leaving meals in resident rooms was not acceptable; the tray should have been collected. On 4/14/16, at 9:31 a.m. the director of nursing (DON) confirmed the facility currently did not have a system in place to track the delivery and collection of meal trays. The DON then stated we need to develop a better system to ensure all room trays are collected in a timely manner. The facility's Meal Service policy, dated 4/14 indicated room trays would be removed from the resident room within 2 hours after meal delivery. On 4/14/16, at 10:30 a.m. the maintenance director verified the following: -Room 201: There was build-up of dark debris/dirt along the edges of the floor. -Room 205: There was build-up of dark debris/dirt along the edges of the floor. -Room 308: The inside of the bathroom door was badly gouged/scraped, exposing bare wood. The	F 465		

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F 465	Continued From page 15 bathroom door frame was scratched and the room heat register was scraped. -Room 310: The bathroom wall paper was curling up on the bottom, in the seam and had black marred areas above the baseboard. The word "window" was written in black letters on the wall paper. The baseboard on the corner to the right of the bathroom door had a large piece broken off. The heat register was scraped and marred. -Room 312: The porcelain finish in the bathroom sink was cracked and the ridges were easily felt and was not cleanable. The inside of the bathroom door was deeply scratched, exposing bare wood. The heat register was scratched and marred. The maintenance director stated the sink needed to be replaced. -Room 315: The inside of the room and the bathroom doors were badly gouged, up high and down low, exposing bare wood, and the edges of the door were badly nicked, causing rough, sharp edges. The bathroom door frame was scratched. The heat register was scratched. The maintenance director stated the bathroom door needed to be replaced. -Room 317: The inside of the bathroom door was badly scraped, exposing bare wood. -Room 407: The bathroom tile had a yellow stain next to toilet and was cracked around the base of the toilet. There were dark stains in the cracks. The bathroom wall next to toilet waas soiled. The maintenance director verified the soiled areas needed to be cleaned and the scraped	F 465		

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F 465	Continued From page 16 doors and registers required repairs. The maintenance director stated monthly rounds were done in each room and verified the above concerns had not been identified on the monthly rounds or by staff. The Monthly Quality Assurance Rounds dated 3/14/16, lacked identification of the resident room concerns identified on the environmental tour. The undated Monthly Quality Assurance Checklist indicated the doors, floors and walls were to be inspected monthly, recorded and corrected monthly.	F 465		

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	245491	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/12/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Augustana Mercy Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/05/2016

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	K 000		

By e-mail to both:
Marian.Whitney@state.mn.us
and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency

Augustana Mercy Care Center is a 1-story building with small partial basement. The original building was constructed in 1964 and additions constructed in 1968 and 1977, all of Type II(111 construction). A single story hospital adjoins the nursing home and is separated by a 4 hour wall. To the south a single story type V(111) assisted living facility also adjoins and is separated by 4 hour construction with a 3 hour rated, self closing door. Therefore, the nursing home was inspected as one building.

The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification.

The facility has a licensed capacity 72 beds and

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	245491	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/12/2016**

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K 000	Continued From page 2 had a census of 70 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 017 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility had penetrations located in the ceiling tile located in the facility that are not in compliance with NFPA Life Safety Code 101 (00) Sections 19.3.6.2 and 8.2.4.4.1 in resisting the passage of smoke. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect 12 of 66 residents, as well as an undetermined number of staff, and visitors of the facility. Findings include: On facility tour between 9:00 AM to 1:00 PM on 04/12/2016, observations revealed, that there are	K 017	K17- holes in wall by kiosk 25 The holes were repaired on 4/28. All hallway walls were examined for penetrations to the walls that may break the smoke barrier. Any holes identified were fixed by 5/15/16. All staff were in-serviced on the process for reporting repair needs on 4/21/15. The Maintenance Director or designee will audit the hallway walls on a quarterly basis. Items identified will be repaired.	5/15/16

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K 017	Continued From page 3 five 1/2 inch diameter holes in the corridor wall by resident room 405 just above the wall mounted computer. This deficient condition was verified by a Maintenance Supervisor.	K 017		
K 029 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 1 of several smoke barrier walls construction that meet the requirements of NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections 19-3.7.3 and 8.3. This deficient practice could affect 10 of 66 residents, as well as an undetermined number of staff, and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include: On facility tour between 9:00 AM to 1:00 PM on 04/12/2016, observations revealed that the double door to the loading/receiving dock is in an area that is also open to a soiled linen room has a gap greater than 1/4 of an inch between the door leaves.	K 029	The gap was repaired on 4/21/16. All smoke barrier doors were examined for gaps greater than ¼" Any holes identified were fixed by 5/24/16. The Maintenance Director or designee will audit the hallway walls on a quarterly basis. Items identified will be repaired.	5/24/16

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AUGUSTANA MERCY CARE CENTER	**710 SOUTH KENWOOD AVENUE** **MOOSE LAKE, MN 55767**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 4 This deficient condition was verified by a Maintenance Supervisor.	K 029		
K 051 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observation and staff interview it was revealed that the facility failed to correctly install manually actuated alarm-initiating devices throughout the facility in accordance with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections 19.3.4.2 and 9.6.2, NFPA 72 National Fire Alarm Code (99), Sections 2-8.1 and 2-8.2, and the MN State Fire Code 907.3.3.1. This deficient condition could adversely affect the ability to initiate the fire alarm system and delay emergency actions, and emergency forces	K 051	The pull box was move/lowered to the appropriate code height on 4/28/16. The Maintenance Director measured other fire pull boxes and found them to be in compliance. A smoke detector was placed with in 5" of the fire panel on 4/22/16	4/28/16

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	245491	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/12/2016**

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K 051	Continued From page 5 notification in the event of an emergency, thus negatively affecting 20 of 66 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 9:00 AM to 1:00 PM on 04/12/2016, observation revealed that the Manual fire alarm box L1M12 located by the smoke barrier door FD66 and the west wing nurses station was mounted at 60 inches above the floor level which is higher than the maximum 54 inches as stated in NFPA 72 (99) This deficient practice was confirmed by the Maintenance Supervisor.	K 051		
K 052 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4, and 9.6, as well as 1999 NFPA 72, Section 1-5.6. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting 66 of 66 residents as well as an undetermined number of staff, and visitors to the facility.	K 052	A smoke detector was installed within five feet of the fire alarm control panel on 4/18/16 by a qualified vendor.	4/18/16

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K 052	Continued From page 6 Findings include: On facility tour between 9:00 AM to 1:00 PM on 04/12/2016, observations revealed that the room where the facility's fire alarm control panel is located was not protected by smoke detection. This deficient condition was verified by a Maintenance Supervisor.	K 052		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NAPA 13 the Standard for the Installation of Sprinkler Systems 1999 edition. The failure to maintain the sprinkler system in compliance with NAPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that could affect 66 of 66 residents, as well as an undetermined number of staff, and visitors. Findings include:	K 056	The mission escutcheon ring identifies was replaced on 4/18/16. All sprinkler heads were examined. Any identified missing escutcheon rings were replaces by 5/24/16. If ceiling work or sprinkler work is performed. The Maintenance Director will inspect the area once the work is completed to ensure all escutcheon rings are in place. The gauge located on the main fire sprinkler riser was replaced and inspected on by 5/24/16. The replacement has been placed on the preventive maintenance calendar for April of 2021.	5/24/16

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K 056	Continued From page 7 On facility tour between 9:00 AM to 1:00 PM on 04/12/2016, observations reveled the following deficient conditions affecting the facility's fire sprinkler system: 1. There is an escutcheon ring missing from the sprinkler head located at the west wind nurses station, and 2. The gauge the is located on the facility's main fire sprinkler riser was last tested or replaced on 05/23/2006 and not every 5 years as required by the NFPA 13 (99) code. This deficient practice was confirmed by the Maintenance Supervisor.	K 056		

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivererd
April 28, 2016

Ms. Kim Tyson, Administrator
Augustana Mercy Care Center
710 South Kenwood Avenue
Moose Lake, MN 55767

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5491025

Dear Ms. Tyson:

The above facility was surveyed on April 11, 2016 through April 14, 2016 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, Health Regulation 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 one of the following:

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, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

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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 April 11, through April 14, 2016, 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		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure that 1 of 1 residents (R134) received health information in a manner that was understandable and provided at a time that was most useful to the resident. Findings include R134's face sheet identified diagnoses that included cervical radiculopathy (damage to nerve due to compression in the cervical vertebra), arthrodesis (fusion) of the cervical vertebra, anxiety and depression.	2 555	F154; It is the policy of Augustana Mercy Health Care Center to fully inform residents in advance about changes on their care and treatment. An initial care conference was held with resident R134 on 4/15/16 she reported that she was in agreement with her plan of care and had no further concerns. On 4/15/16 facility social worker met with resident R134 and provided her with the medical records consent form the resident was provided with instructions on how to request copies of her medical record. All facility staff	5/11/16

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2 555	Continued From page 3 According to R134's progress notes, she was cognitively intact and able to make her own health care decisions. In an interview on 4/13/16, at 9:57 a.m., family member (FM)-B stated when R134 was admitted to the facility, they felt the paperwork was incorrect. FM-B said they asked registered nurse (RN)-G if they could see the interagency referral and they were refused. According to FM-B (RN-G was unavailable during the survey), RN-G told them once an interagency referral is in their hands it is the facility's property. FM-B stated they had questions about R134's medications, amount of assistance recommended, and if R134 could shower. FM-B did not feel that the facility answered their questions in a timely manner or in a manner that R134 could understand. FM-B also stated it was a good thing he was there, as he provided all cares for R134 during the first few days she was in the facility. In an interview on 4/14/16, at 1:53 p.m., the director of nursing (DON) stated RN-G usually talked to families or residents upon admission. The DON stated residents can look at anything in their medical record, usually the same day or the next day. The DON clarified the facility usually had a nurse sit with them to interpret the medical content. If a resident or their power of attorney wants a copy, the facility has a standard consent form to sign. In an interview on 4/14/16, at 1:59 p.m. R134 stated she was admitted on a Monday and it was a rough start. R134 stated they were greeted by RN-G and gave her the referral packet from the	2 555	were re- educated on 4 /21/16 on procedure for addressing concerns and medical records requests in the event a resident requests their medical records. All staff that assist in care and treatment plans will be educated on the need to fully inform residents in advance about any changes on their care and treatment. At Care Conferences the resident/responsible party will be asked if they have been informed in advance about changes to their care and if the explanation was understandable. The DON or designee will complete five random audits per week for 4 weeks and then five per month for 3 months to ensure compliance. All results will be reviewed by the facility quality assurance committee to determine further compliance needs. Corrected by 5/11/16	

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2 555	Continued From page 4	2 555		

hospital. R134 stated she had surgery on her neck and she was a registered nurse.

R134 stated later on in the day she was admitted, or the next day, she asked about her instructions, appointments, restrictions, assistance needed, basically what the "game plan was". R134 stated she asked to see the interagency packet or get a copy of it. R134 said it was very awkward because they were in a public area and she was told no. R134 said she knows it was her right to see her health information, and said so at the time. According to R134, the unidentified staff person asked her "what exactly are you asking for?". R134 reported she replied, she just had a lot of questions. The staff person then told her, "they would have to check on that."

R134 said RN-B did come in another day after that and go through the chart with her, however, R134 said she had questions and didn't feel that they were answered by RN-B, even at that time. Questions such as: Why isn't a gait belt being used? Am I supposed to use a wheelchair or a walker? Am I supposed to have assistance when I transfer?. R134 continued to state the chart was held at lap level, so with her neck brace on, it was hard to see the chart and she felt that she couldn't truly review it.

R134 also stated when she received her medications she did not recognize them all and asked the unidentified staff person what "the little white pill" was. The staff person replied that they did not know and would have to check on it. R134 said it was "freaky" to take pills from someone who didn't know what they were. R134 said they told her later that it was just Pepcid (for stomach acid). To further her frustration, staff couldn't tell R134 when they were prescribed or

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2 555	Continued From page 5 why. R134 said she had a swallow study and was told not to take pills without them being crushed. However, sometimes she was getting pill crushed, and other times not. R134 said there was a discrepancy between the interagency paperwork and the implementation of assistance in the facility. R134 stated she was transferring herself and had been throughout her stay, but she never knew what the recommendations was from the hospital. In an interview on 4/14/16, at 2:19 p.m., RN-B stated there were discrepancies in the paperwork received from the referring hospital. RN-B stated she had to call the referring hospital and clinic many times to get the correct orders. RN-B stated she did bring R134's chart to her room and review it with her. However, RN-B stated she told FM-B that they would have to call the referring hospital for a copy of the Interagency Referral Form. RN-B stated R134 was self-transferring at the time of admission and the paperwork indicated R134 was an assist of 1 with front wheeled walker. In an interview on 4/14/16, at 2:42 p.m., R134 stated she asked a staff person if there was a shower nearby, as she hadn't been asked about a bath or shower. R134 reported she was told "no", with no other information. A day or so later someone told her bath days are Tuesdays. R134 wondered why someone couldn't have said, "I don't know, but let me find out and I'll let you know; or, would you like to have a shower today?"	2 555		

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2 555	Continued From page 6 R134 said the staff, including the therapists, didn't seem to know what the plan was for her, and everyone kept asking her the "game plan", but she had no idea. R134 said even though they are planning a care conference, she did not feel involved in her care. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or her designee could develop policies and procedures to ensure residents or their representative actively participates in the development of a comprehensive care plan. All appropriate staff could be educated on the process of resident/representative involvement. The Director of Nursing or her designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 555		
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.	21426		4/25/16

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21426	Continued From page 7 (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure two-step tuberculin skin tests (TST) were completed for 2 of 5 employees. Findings include: Licensed practical nurse (LPN)-B's employment start date was 12/22/15. LPN-B received the first-step TST on 12/16/15. LPN-B had not received the second-step TST, and had not provided evidence of a negative TST dated within 90 days prior to date of hire. Nursing Assistant (NA)-F's employment start date was 2/27/16. NA-F received the first-step TST on 2/23/16. NA-F had not received the second-step TST, and had not provided evidence of a negative TST dated within 90 days prior to date of hire. The facility policy and procedure for TB (tuberculosis) Prevention and Control Guidelines revised 2/15, directed all health care workers would receive a baseline TB screening to include an evaluation of risk factors for active TB disease and testing for the presence of infection with TB by either a two-step TST or TB blood test. Employees were to receive TB screening prior to starting work, including a first step TST.	21426	It is the policy of Augustana Mercy Health Care Center to ensure that all employees are tested for TB with a 2-step tuberculin skin as required. An audit was conducted on all employee files to ensure that all employees had the 2-step skin test or other acceptable method of TB testing. All staff were educated on need to complete 2-step process upon hire. A procedure was developed for the tracking of new employee TB tests. The Human Resources Director or designee will audit all new employee files as they are hired for the next 3 months to ensure compliance with results being reported to QA committee to determine further compliance needs. Corrected by 4/25/16.	

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21426	Continued From page 8 The Minnesota Department of Health Regulations for Tuberculosis Control in Minnesota Health Care Settings dated 6/13, directed an employee may begin working with patients after a negative TB symptom screen and a negative TST dated within 90 days before hire. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or her designee could develop systems to ensure TB screenings for staff are completed according to the Center for Disease Control recommendations. The DON or her designee could educate all appropriate staff on these systems. The DON or her designee could develop monitoring systems tto ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21426		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure collection of unconsumed food items on meal trays which did not provide a clean and pleasant room environment for 1 of 3 residents (R106) reviewed for nutrition. In addition, the facility failed to ensure ensure walls, doors, and floors were properly maintained to provide a cleanable and	21665	It is the policy of Augustana Mercy Health Care Center to ensure a clean and pleasant environment in the facility. Meal tray was removed from resident R106 as soon as the error was noted. All staff will be educated on importance of picking up meal trays within two hours of the meal served. A new procedure for tracking	5/24/16

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21665	Continued From page 9 home-like environment in 8 of 30 resident rooms (201, 205, 308, 310, 312, 315, 317, and 407) reviewed for environment. Findings include: On 4/12/16, at 2:01 p.m. a meal tray was observed on a table located to the right of R106's bed. The meal tray had a plate with a plastic dome which covered unconsumed foods including: a scrambled egg, two pieces of bacon and toast. Upon entering R106's room there was an obvious, foul odor. R106 reported the meal tray was delivered to her room on 4/12/16 around 7:00 a.m., (7 hours earlier). R106 reported staff forgot to come back to the room to pick up the food, then stated, the breakfast food on the tray had made a very unpleasant smell in the room all day. On 4/12/16, at 2:28 p.m. a staff member was observed collecting lunch trays from other resident rooms, R106's breakfast tray remained in the room on the table. On 4/12/16, at 2:44 p.m. nursing assistant (NA)-A reported the nursing assistants are to pass and pick up the meal trays for those residents that wish to eat in their room, then document intakes. NA-A reported she was unsure which staff member delivered the breakfast tray to R106. Upon request, NA-A removed the meal tray from R106's room. NA-A lifted the plastic dome off of the plate to identify the food items and stated, "oh that stinks." NA-A confirmed the eggs, bacon and toast were served in the morning and should have been picked up after breakfast. On 4/12/16, at 2:47 p.m. licensed practical nurse (LPN)-A reported the nursing assistants were to	21665	room trays being delivered and picked up will be implemented. The DON or a designee will audit room tray pass on 5 residents per week for 4 weeks and then 5 residents per month for 3 months with results being reported to Quality assurance committee to determine further compliance needs. Staff education was provided on 4/21/16 regarding need to report all maintenance concerns in rooms as soon as they are noted. Maintenance staff has made all necessary repairs to the rooms outlined in the 2567 report. Audits will be made of all resident rooms and repairs will be completed. 10 room maintenance audits will be completed monthly with Maintenance Director and reported to QA Administrator for review. Corrected by 5/24/15	

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21665	Continued From page 10	21665		

pass and pick up all meal trays. If for some reason the staff could not complete the task they would communicate that to the nurses. LPN-A stated that was not the case today, and confirmed she worked the unit in which R106 resided. LPN-A stated R106's breakfast tray was delivered on 4/12/16 around 8:00 a.m., and was not removed until requested at 2:44 p.m..

Review of the Augustana Mercy Care Center Dining Menu Dated 4/12/16, identified breakfast was a cheese omelette, bacon, wheat toast.

On 4/13/16, at 8:00 a.m. R106 was observed to ambulate independently to the dining room. R106 was able to eat and drink independently.

On 4/13/16, at 8:40 a.m. R106 was resting on the bed, a plate with a plastic dome rested on a table next to R106's bed. There was unconsumed food on the plate which included french toast and a hash brown triangle. R106 reported the food on the plate, the french toast and hash brown triangle was brought in last night for supper and had been there ever since. R106 stated staff never came to get it, then "I guess the staff think I am invisible in here."

On 4/13/16, at 8:59 a.m. upon request, registered nurse (RN)-A removed the meal tray from R106's room. RN-A confirmed the french toast and hash brown triangle were served the previous day for supper (15 hours earlier). RN-A further stated leaving meals in resident rooms was not acceptable; the tray should have been collected.

On 4/14/16, at 9:31 a.m. the director of nursing (DON) confirmed the facility currently did not have a system in place to track the delivery and collection of meal trays. The DON then stated we

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21665	Continued From page 11 need to develop a better system to ensure all room trays are collected in a timely manner. The facility's Meal Service policy, dated 4/14 indicated room trays would be removed from the resident room within 2 hours after meal delivery. On 4/14/16, at 10:30 a.m. the maintenance director verified the following: -Room 201: There was build-up of dark debris/dirt along the edges of the floor. -Room 205: There was build-up of dark debris/dirt along the edges of the floor. -Room 308: The inside of the bathroom door was badly gouged/scraped, exposing bare wood. The bathroom door frame was scratched and the room heat register was scraped. -Room 310: The bathroom wall paper was curling up on the bottom, in the seam and had black marred areas above the baseboard. The word "window" was written in black letters on the wall paper. The baseboard on the corner to the right of the bathroom door had a large piece broken off. The heat register was scraped and marred. -Room 312: The porcelain finish in the bathroom sink was cracked and the ridges were easily felt and was not cleanable. The inside of the bathroom door was deeply scratched, exposing bare wood. The heat register was scratched and marred. The maintenance director stated the sink needed to be replaced. -Room 315: The inside of the room and the bathroom doors were badly gouged, up high and	21665		

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21665	Continued From page 12 down low, exposing bare wood, and the edges of the door were badly nicked, causing rough, sharp edges. The bathroom door frame was scratched. The heat register was scratched. The maintenance director stated the bathroom door needed to be replaced. -Room 317: The inside of the bathroom door was badly scraped, exposing bare wood. -Room 407: The bathroom tile had a yellow stain next to toilet and was cracked around the base of the toilet. There were dark stains in the cracks. The bathroom wall next to toilet was soiled. The maintenance director verified the soiled areas needed to be cleaned and the scraped doors and registers required repairs. The maintenance director stated monthly rounds were done in each room and verified the above concerns had not been identified on the monthly rounds or by staff. The Monthly Quality Assurance Rounds dated 3/14/16, lacked identification of the resident room concerns identified on the environmental tour. The undated Monthly Quality Assurance Checklist indicated the doors, floors and walls were to be inspected monthly, recorded and corrected monthly. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of ensuring meal trays are picked dup in a timely manner to avoid odors. The maintenance director could develop systems to ensure resident areas	21665		

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21665	Continued From page 13 are kept safe and clean. The DON and director of maintenance could educate all appropriate staff and monitor systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21665		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a dignified dining experience in 1 of 2 resident dining rooms. In addition, the facility failed to ensure dignity was maintained during personal cares for 1 of 3 residents (R12) reviewed for dignity. Findings include: During a dining observation on 4/11/16, from 5:40 p.m. until 6:26 p.m., residents were seated at 11 tables in the facility dining room. In addition to a room full of residents, 3 family members were at tables visiting. Approximately half of the residents had been served dinner, and the others were sitting with beverages. By 6:11 p.m., approximately half of the residents	21805	It is the policy of Augustana Mercy Health care center to ensure that dignity is provided for all residents at all times. All facility staff were provided education on 4/21/16 regarding dignity during dinning and with personal cares in regards to language and privacy. The Dietary Director or designee will complete five random dinning room audits weekly for 4 weeks then five monthly for 3 months to ensure compliance with results being reviewed by the quality assurance committee to determine further compliance needs Corrected by 5/11/16. The DON or designee will complete five random audits of personal cares provided by staff weekly for x 4 weeks then five monthly for 3 months with the results being reviewed by quality assurance	5/11/16

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21805	Continued From page 14 had been served their meal and staff were continuing to bring food out for the residents. At 6:13 p.m., nursing assistant (NA)-A, was walking between dining room tables to the kitchen and stated to a staff person following behind her, "We don't feed the feeders until last." Several tables of residents, including residents who needed assistance with their meal, were within earshot of this statement. In an interview on 4/11/16, at 6:20 p.m., NA-A again stated they feed "feeders" last. NA-A confirmed she had used that word to describe residents who needed assistance with eating. NA-A agreed it may not be a respectful reference for a person. In an interview on 4/14/16, at 1:43 p.m., the director of nursing (DON) stated she would expect staff not to use the term "feeder" in reference to residents. The DON stated they, "don't want staff to be saying that." R12 felt bad when chided for her frequent need to use the commode. R12 used a commode just behind a curtain and at times her roommate had visitors. In addition, staff would open R12's window while she was on the commode so they can have "fresh air". R12's face sheet indicated diagnoses which included frequency of micturition (frequent need to urinate), edema, muscle weakness and chronic kidney disease. R12's Physician Order Report, dated 4/14/16, indicated R12 received 40 milligrams (mg) of Lasix, a diuretic, twice a day, at 8:00 a.m. and 12:00 noon.	21805	committee to determine further compliance needs . Corrected by 5/11/16	

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21805	Continued From page 15 R12's quarterly Minimum Data Set (MDS), dated 2/16/16, indicated R12 had moderate impairments in cognition, was always continent of bladder and bowel, and had no signs of delirium or behaviors. R12's toileting care plan, dated 2/22/16, indicated R12 was to be toileted every two hours and prior to 11:30 a.m. (lunch). The goal indicated to have R12 maintain bladder continence on the day shift. In an interview on 4/11/16, at 4:04 p.m., R12 stated staff don't always treat her with respect and dignity. R12 stated she waited and waited for staff to answer her call light, and when she had to go, she had to go. R12 continued to explain the staff would come to the door, turn off the call light and say they would return in a few minutes, but they didn't return. R12 said she would have to put her call light on again. In an observation on 4/13/16, beginning at 12:57 p.m., R12 and her roommate were in their room. The roommate had a male visitor. R12's call light came on and two staff responded with a Hoyer lift at 12:59 p.m. At 1:09 p.m., R12's light came back on. At 1:17 p.m., two aides entered the room and shut the door. At 1:21 p.m., R12's roommate and visitor exited the room and went to the day room. At 1:24 p.m., R12 was sitting in her room, in her wheelchair reading a book. In an interview on 4/13/16, at 1:32 p.m., nursing assistant (NA)-F stated R12 used a commode in the bedroom because she needed a Hoyer lift for transfers and there was not enough room to move around the roommate into the bathroom. NA-F showed her group sheet where she had indicated R12's use of the commode at 1:16 p.m.	21805		

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21805	Continued From page 16 In a telephone interview on 4/14/16, at 10:13 a.m., family member (A) stated they have been told that they can't get the Hoyer lift into the bathroom so R12 used a commode in the bedroom. FM-A stated it's an issue of using the commode when R12's roommate has company. FM-A stated R12 has to sit behind the curtain and the staff don't ask the roommate's company to leave. FM-A stated the staff will at times, open the window for "fresh air" while R12 used the commode. FM-A also stated when staff did that, air blew right on R12 while she is sitting on the commode. FM-A stated they have brought up the use of the commode and the cleanliness of the commode at care conferences. FM-A stated the cleanliness of the commode was addressed, but not the privacy and dignity issues. FM-A also stated R12 has frequent urges to urinate and she worried about "wetting herself". FM-A had observed the staff answer R12's light and say, "You just went". FM-A wondered if there was a limit on the number of times a resident can use the commode. In an interview on 4/14/16, at 11:04 a.m., R12 stated that while the curtain did get pulled, residents should have a little more privacy. R12 stated she lost her bathroom privileges, now that she needed the lift, but she "can't help it." R12 also stated staff told her she's not the only one and they're "so snotty". In an interview on 4/14/16, at 11:42 a.m., registered nurse (RN)-A stated she hoped that staff would ask the visitor to step out of a room while a resident is using the commode. RN-A reiterated that staff should ask family and visitors to step out for a few minutes. RN-A stated it was a dignity issue for residents. RN-A continued she	21805		

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21805	Continued From page 17 got frustrated with staff who were frustrated with residents who have urge issues. RN-A stated she educated staff that you can t make someone "go less", you have to assist them. RN-A stated she explained to staff that an urge to urinate is not a behavior and they can't tell a resident they can't go. Policies on privacy and dignity were requested but not received. SUGGESTED METHOD OF CORRECTION: The interdisciplinary team (IDT)or designee could develop, review, and/or revise policies and procedures to ensure all residents' dignity is maintained. The IDT or designee could educate all staff on the policies and procedures. The IDT or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	21805		
21860	MN St. Statute 144.651 Subd. 16 Patients & Residents of HC Fac.Bill of Rights Subd. 16. Confidentiality of records. Patients and residents shall be assured confidential treatment of their personal and medical records, and may approve or refuse their release to any individual outside the facility. Residents shall be notified when personal records are requested by any individual outside the facility and may select someone to accompany them when the records or information are the subject of a personal interview. Copies of records and written information from the records shall be made available in accordance with this subdivision and section 144.335. This right does not apply to	21860		5/11/16

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21860	Continued From page 18 complaint investigations and inspections by the Department of Health, where required by third party payment contracts, or where otherwise provided by law. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure that 1 of 1 residents (R134) received health information in a manner that was understandable and provided at a time that was most useful to the resident. Findings include R134's face sheet identified diagnoses that included cervical radiculopathy (damage to nerve due to compression in the cervical vertebra), arthrodesis (fusion) of the cervical vertebra, anxiety and depression. According to R134's progress notes, she was cognitively intact and able to make her own health care decisions. In an interview on 4/13/16, at 9:57 a.m., family member (FM)-B stated when R134 was admitted to the facility, they felt the paperwork was incorrect. FM-B said they asked registered nurse (RN)-G if they could see the interagency referral and they were refused. According to FM-B (RN-G was unavailable during the survey), RN-G told them once an interagency referral is in their hands it is the facility's property. FM-B stated they had questions about R134's medications, amount of assistance	21860	It is the policy of Augustana Mercy Health Care Center to fully inform residents in advance about changes on their care and treatment. An initial care conference was held with resident R134 on 4/15/16 she reported that she was in agreement with her plan of care and had no further concerns. On 4/15/16 facility social worker met with resident R134 and provided her with the medical records consent form the resident was provided with instructions on how to request copies of her medical record. All facility staff were re- educated on 4 /21/16 on procedure for addressing concerns and medical records requests in the event a resident requests their medical records. All staff that assist in care and treatment plans will be educated on the need to fully inform residents in advance about any changes on their care and treatment. At Care Conferences the resident/responsible party will be asked if they have been informed in advance about changes to their care and if the explanation was understandable. The DON or designee will complete five random audits per week for 4 weeks and then five per month for 3 months to ensure compliance. All results will be reviewed by the facility quality assurance committee to	

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21860	Continued From page 19	21860		

recommended, and if R134 could shower. FM-B did not feel that the facility answered their questions in a timely manner or in a manner that R134 could understand. FM-B also stated it was a good thing he was there, as he provided all cares for R134 during the first few days she was in the facility.

In an interview on 4/14/16, at 1:53 p.m., the director of nursing (DON) stated RN-G usually talked to families or residents upon admission. The DON stated residents can look at anything in their medical record, usually the same day or the next day. The DON clarified the facility usually had a nurse sit with them to interpret the medical content. If a resident or their power of attorney wants a copy, the facility has a standard consent form to sign.

In an interview on 4/14/16, at 1:59 p.m. R134 stated she was admitted on a Monday and it was a rough start. R134 stated they were greeted by RN-G and gave her the referral packet from the hospital. R134 stated she had surgery on her neck and she was a registered nurse.

R134 stated later on in the day she was admitted, or the next day, she asked about her instructions, appointments, restrictions, assistance needed, basically what the "game plan was". R134 stated she asked to see the interagency packet or get a copy of it. R134 said it was very awkward because they were in a public area and she was told no. R134 said she knows it was her right to see her health information, and said so at the time. According to R134, the unidentified staff person asked her "what exactly are you asking for?". R134 reported she replied, she just had a lot of questions. The staff person then told her, "they would have to check on that."

determine further compliance needs.
Corrected by 5/11/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00049	A. BUILDING: _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA MERCY CARE CENTER	710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767

(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) COMPLETE DATE
21860	Continued From page 20 R134 said RN-B did come in another day after that and go through the chart with her, however, R134 said she had questions and didn't feel that they were answered by RN-B, even at that time. Questions such as: Why isn't a gait belt being used? Am I supposed to use a wheelchair or a walker? Am I supposed to have assistance when I transfer?. R134 continued to state the chart was held at lap level, so with her neck brace on, it was hard to see the chart and she felt that she couldn't truly review it. R134 also stated when she received her medications she did not recognize them all and asked the unidentified staff person what "the little white pill" was. The staff person replied that they did not know and would have to check on it. R134 said it was "freaky" to take pills from someone who didn't know what they were. R134 said they told her later that it was just Pepcid (for stomach acid). To further her frustration, staff couldn't tell R134 when they were prescribed or why. R134 said she had a swallow study and was told not to take pills without them being crushed. However, sometimes she was getting pill crushed, and other times not. R134 said there was a discrepancy between the interagency paperwork and the implementation of assistance in the facility. R134 stated she was transferring herself and had been throughout her stay, but she never knew what the recommendations was from the hospital. In an interview on 4/14/16, at 2:19 p.m., RN-B stated there were discrepancies in the paperwork received from the referring hospital. RN-B stated	21860		

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21860	Continued From page 21 she had to call the referring hospital and clinic many times to get the correct orders. RN-B stated she did bring R134's chart to her room and review it with her. However, RN-B stated she told FM-B that they would have to call the referring hospital for a copy of the Interagency Referral Form. RN-B stated R134 was self-transferring at the time of admission and the paperwork indicated R134 was an assist of 1 with front wheeled walker. In an interview on 4/14/16, at 2:42 p.m., R134 stated she asked a staff person if there was a shower nearby, as she hadn't been asked about a bath or shower. R134 reported she was told "no", with no other information. A day or so later someone told her bath days are Tuesdays. R134 wondered why someone couldn't have said, "I don't know, but let me find out and I'll let you know; or, would you like to have a shower today?" R134 said the staff, including the therapists, didn't seem to know what the plan was for her, and everyone kept asking her the "game plan", but she had no idea. R134 said even though they are planning a care conference, she did not feel involved in her care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could spected an dupheld. The DON could inservice staff regarding the regulation and rights to access to personal medical records. An periodic audit could be conducted to ensure compliance and the findings could be communicated to the quality assurance committee.	21860		

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21860	Continued From page 22 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21860		