DEPARTMENT OF	HEALTH AN	D HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES
		MEDIC	ARE/MEDICAL	D CERTIFIC	CATION A	AND TRANSMITTAL	ID: PE4L
		PART I -	TO BE COMPI	LETED BY 1	THE STAT	FE SURVEY AGENCY	Facility ID: 00049
1. MEDICARE/MEDICAID	PROVIDER NO		3. NAME AND AL			CED.	4. TYPE OF ACTION: <u>7 (</u> L8)
(L1) 245491			(L3) AUGUSTAN (L4) 710 SOUTH			IEK	1. Initial 2. Recertification
2.STATE VENDOR OR ME (L2) 857637200	DICAID NO.		(L5) MOOSE LA		AVENUE	(L6) 55767	3. Termination4. CHOW5. Validation6. Complaint
	NCE OF OUNE	DGUUD		,			7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHA (L9) 09/01/2010	INGE OF OWNE	RSHIP	7. PROVIDER/SU	OPPLIER CATEC	JORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY	06/09/2016	(L34)	01 Hospital 02 SNF/NF/Dual	05 HHA 06 PRTF	09 ESKD 10 NF	14 CORF	
 BATE OF SORVET ACCREDITATION STAT 		(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID		FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 2 AOA	1 TJC 3 Other	(====)	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30
11LTC PERIOD OF CERT	IFICATION		10.THE FACILITY	IS CERTIFIED	AS:		
From (a):			X A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirements:
To (b) :			0	equirements		2. Technical Personnel	6. Scope of Services Limit
			Compliance	e Based On:		3. 24 Hour RN	7. Medical Director
12. Total Facility Beds	7	2 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN	NF)8. Patient Room Size
13.Total Certified Beds		2 (L17)	B. Not in Comp	liance with Progr	am	5. Life Safety Code	9. Beds/Room
			Requirements	and/or Applied	Waivers:	* Code: A	(L12)
14. LTC CERTIFIED BED E	BREAKDOWN					15. FACILITY MEETS	
18 SNF 13	8/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
	72						
(L37)	(L38)	(L39)	(L42)	(L43)			
17. SURVEYOR SIGNATU	IRE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Kathie Killoran, H	HFE NEII		0	6/30/2016	(L19)	Mark Meath	, Enforcement Specialist 08/19/2016 (L2)
	PART II	- TO BE	COMPLETED I	BY HCFA RI	EGIONAI	OFFICE OR SINGLE S	STATE AGENCY
19. DETERMINATION OF	ELIGIBILITY		20. COM	IPLIANCE WIT	H CIVIL		ncial Solvency (HCFA-2572)
X 1. Facility is E	ligible to Particip	ate	RIGH	ITS ACT:		 Ownership/Control Both of the Above 	ol Interest Disclosure Stmt (HCFA-1513) e :
2. Facility is a	not Eligible						
		(L21)					
22. ORIGINAL DATE	23.1	LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	: (L30)
OF PARTICIPATION		BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 00	INVOLUNTARY
07/01/1987						01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)		(L41)		(L25)		02-Dissatisfaction W/ Reimburs	ement 06-Fail to Meet Agreement
25. LTC EXTENSION DA	ГЕ: 27.	ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	on <u>OTHER</u>
	L	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
	(L27)			(L44)			00-Active
	(127)	B. Rescind Si	uspension Date:				
				(L45)			
28. TERMINATION DATE	•	29	9. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
			03001				
	(L	.28)			(L31)		
31. RO RECEIPT OF CMS-	1539	32	2. DETERMINATION	OF APPROVAL	L DATE		
		22)	05/24/2016		(122)		ROUAL
	(L	32)			(L33)	DETERMINATION APP	KUVAL



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



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,

Kumalu Fiske Downing

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

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building		DATE OF REVIS	SIT
	B. Wing	Y2	6/9/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUSTANA MERCY CARE C	ENTER	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	DATE	ITEM	DATE	ITEM		DATE
Y4	Y5	Y4	Y5	Y4		Y5
ID Prefix F0154 483.10(b)(3), 483.		ID Prefix F0241		ID Prefix	F0258 483.15(h)(7)	Correction
Reg. # (2)	Completed	Reg. #	Completed	Reg. #	400.10(1)(7)	Completed
LSC	05/11/2016		05/16/2016	LSC		05/24/2016
ID Prefix F0465	Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	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		
		DATE	SIGNATURE OF SURVEYOR		DATE	
	INITIALS) TA/kfd	6/17/2016	29	625	6	/9/2016
	REVIEWED BY INITIALS)	DATE	TITLE		DATE	
FOLLOWUP TO SURVEY (4/14/2016	COMPLETED ON		R ANY UNCORRECTED DEFICIEN CTED DEFICIENCIES (CMS-2567)	NCIES. WAS SENT TO TH		S 🗌 NO

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01		DATE OF R	EVISIT	
	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).

ITE	М	DATE	ITEM			DATE	ITEM			DATE
Y4		Y5	Y4			Y5	Y4			Y5
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	IFPA 10)1	Completed	Reg. #	NFPA 101		Completed
LSC	K0017	05/15/2016	LSC K	(0029		05/24/2016	LSC	K0051		04/28/2016
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	IFPA 1()1	Completed	Reg. #			Completed
LSC	K0052	04/18/2016	LSC K	(0056		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			
REVIEW			DATE	:	SIGNATURE OF	SURVEYOR			DATE	
STATE A		(INITIALS) TL/kfd	6/17/2016	6			27200		5/27	/2016
REVIEWI 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?								



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,

Kumala Fiske Downing

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

STATE FORM: REVISIT REPORT

	MULTIPLE CONSTRUCTION			DATE OF REVIS	SIT
IDENTIFICATION NUMBER	A. Building				
00049 _{V1}	B. Wing		Vo	6/9/2016	Y3
			12		10
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).

ITE	М	DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix	20555	Correction	ID Prefix 21	426	Correction	ID Prefix	21665	Correction
Reg. #	MN Rule 4658.0 Subp. 1	Completed		N St. Statute 144A.04 bd. 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 21	860	Correction	ID Prefix		Correction
Reg. #	MN St. Statute Subd. 5	Completed		N St. Statute 144.651 bd. 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		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
REVIEW		REVIEWED BY (INITIALS) TA/mm	DATE 06/17/201	.6 SIGNATURE OF	SURVEYOR 2962	5	DAT	те 6/09/2016
REVIEW CMS RO		REVIEWED BY (INITIALS)	DATE	TITLE			DAT	E
FOLLOWUP TO SURVEY COMPLETED ON 4/14/2016				FOR ANY UNCORREC RECTED DEFICIENCI				YES 🗌 NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	DICARE/MEDICAID CERTIFICA Γ I - TO BE COMPLETED BY TH			ID: PE4L Facility ID: 00049			
MEDICARE/MEDICAID PROVIDER NO. (L1) 245491 2.STATE VENDOR OR MEDICAID NO. (L2) 857637200 5. EFFECTIVE DATE CHANGE OF OWNERSHIP	 3. NAME AND ADDRESS OF FACILITY (L3) AUGUSTANA MERCY CARE OF (L4) 710 SOUTH KENWOOD AVEN (L5) MOOSE LAKE, MN 7. PROVIDER/SUPPLIER CATEGORY 	CENTER	(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			
(L9) 09/01/2010 6. DATE OF SURVEY 04/14/2016 (L34) 8. ACCREDITATION STATUS:	02 SNF/NF/Dual 06 PRTF 03 SNF/NF/Distinct 07 X-Ray	09 ESRD 10 NF 11 ICF/IID 12 RHC	13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE	8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 09/30			
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 72 (L18)	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	5:	And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: B *	Following Requirements: 6. Scope of Services Limit 7. Medical Director 8. Patient Room Size 9. Beds/Room (L12)			
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF 72 (L37) (L38) (L39)	ICF IID (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 :		18. STATE SURVEY AGENCY APP	PROVAL Date:			
Kathie Killoran, HFE NE II	05/12/2016	(L19)	Kate JohnsTon, Pro	ogram Specialist 05/18/2016 (L20)			
PART II - TO	BE COMPLETED BY HCFA REG	GIONAL	OFFICE OR SINGLE STATI	EAGENCY			
19. DETERMINATION OF ELIGIBILITY _X1. Facility is Eligible to Participate 2. Facility is not Eligible (L21)	20. COMPLIANCE WITH CIV RIGHTS ACT:	ΊL	 Statement of Financia Ownership/Control Ir Both of the Above : 	al Solvency (HCFA-2572) terest Disclosure Stmt (HCFA-1513)			
22. ORIGINAL DATE 23. LTC AGREEM OF PARTICIPATION BEGINNING 07/01/1987		Г	26. TERMINATION ACTION: <u>VOLUNTARY</u> 00 01-Merger, Closure	(L30) <u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety			
(L24) (L41) 25. LTC EXTENSION DATE: 27. ALTERNATIV A. Suspension (L27) B. Rescind Su	of Admissions: (L44)		02-Dissatisfaction W/ Reimbursemen 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	t 06-Fail to Meet Agreement <u>OTHER</u> 07-Provider Status Change 00-Active			
28. TERMINATION DATE: 24	D. INTERMEDIARY/CARRIER NO.		30. REMARKS				
(L28)	03001	(L31)					
31. RO RECEIPT OF CMS-1539 33	2. DETERMINATION OF APPROVAL DATE						
(L32)		(L33)	DETERMINATION APPROV	/AL			



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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

Augustana Mercy Care Center April 28, 2016 Page 3

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.

Augustana Mercy Care Center April 28, 2016 Page 4

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 Augustana Mercy Care Center April 28, 2016 Page 5 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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,

Augustana Mercy Care Center April 28, 2016 Page 6

mark meath

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

		AND HUMAN SERVICES			FORM APPROVED IB NO. 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			X3) DATE SURVEY COMPLETED
		245491	B. WING		04/14/2016
NAME OF	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	
AUGUST	TANA MERCY CARE C	ENTER	1	10 SOUTH KENWOOD AVENUE 100SE LAKE, MN 55767	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 000	INITIAL COMMENT	ſS	F 000		
	as your allegation o Department's accept enrolled in ePOC, y at the bottom of the form. Your electroni be used as verificat				
F 154 SS=D	on-site revisit of you validate that substa regulations has bee your verification. 483.10(b)(3), 483.10	acceptable electronic POC, an ir facility may be conducted to ntial compliance with the in attained in accordance with 0(d)(2) INFORMED OF CARE, & TREATMENTS	F 154		5/11/16
	language that he or	e right to be fully informed in she can understand of his or us, including but not limited to, ondition.			
	advance about care	e right to be fully informed in and treatment and of any or treatment that may affect eing.			
	by: Based on interview facility failed to ensu (R134) received hea	IT is not met as evidenced and document review, the ure that 1 of 1 residents alth information in a manner dable and provided at a time I to the resident.		F154; It is the policy of Augustana M Health Care Center to fully inform residents in advance about changes their care and treatment. An initial ca conference was held with resident R ² on 4/15/16 she reported that she was agreement with her plan of care and no further concerns. On 4/15/16 facil	s on are 134 s in had
ABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	TITLE	(X6) DATE
Electron	ically 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMEN	T OF DEFICIENCIES DF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DAT	0938-039 E SURVEY PLETED
		245491	B. WING		04/	14/2016
NAME OF	PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA MERCY CARE C	ENTER		710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR(DEFICIENCY)	LD BE	(X5) Completic Date
F 154	included cervical ra due to compression arthrodesis (fusion) anxiety and depress According to R134 ⁴ cognitively intact an care decisions. In an interview on 4 member (FM)-B sta to the facility, they f incorrect. FM-B sa (RN)-G if they could and they were refus (RN-G was unavaila told them once an in hands it is the faciliti FM-B stated they has medications, amoun recommended, and did not feel that the questions in a timel R134 could underst a good thing he was cares for R134 duri in the facility. In an interview on 4 director of nursing (talked to families or The DON stated res their medical record next day. The DON had a nurse sit with	dentified diagnoses that diculopathy (damage to nerve n in the cervical vertebra), of the cervical vertebra, sion. s progress notes, she was d able to make her own health /13/16, at 9:57 a.m., family ated when R134 was admitted elt the paperwork was id they asked registered nurse d see the interagency referral sed. According to FM-B able during the survey), RN-G interagency referral is in their ty's property. ad questions about R134's	F 154	4 social worker met with resident F provided her with the medical red consent form the resident was pr with instructions on how to reque of her medical record. All facility were re- educated on 4 /21/16 or procedure for addressing concer medical records requests in the e resident requests their medical re All staff that assist in care and tre plans will be educated on the nee inform residents in advance about changes on their care and treatm Care Conferences the resident/responsible party will be they have been informed in adva about changes to their care and i explanation was understandable, the initial care conference for all residents the IDT team will review care plan with the resident and o responsible party and ensure the able to understand the informatio presented. The RN manager ass the resident will also review the c with the resident and or responsi by day 21 to ensure they underst DON or designee will complete fi random audits per week for 4 we then five per month for 3 months ensure compliance. All results w reviewed by the facility quality ass committee to determine further compliance needs. Corrected by	cords ovided st copies staff ins and event a ecords. eatment ed to fully it any nent. At asked if nce f the During new v the r y are n signed to are plan ole party and. The ve eks and to ill be surance	

CENTE	CENTERS FOR MEDICARE & MEDICAID SERVICES				0	MB NO	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		e survey IPleted
		245491	B. WING			04/	14/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA MERCY CARE C	ENTER					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 154	form to sign. In an interview on 4 stated she was adm a rough start. R134 RN-G and gave her hospital. R134 state neck and she was a R134 stated later or or the next day, she appointments, restr basically what the "g she asked to see th copy of it. R134 said because they were told no. R134 said see her health infort time. According to person asked her "v for?". R134 reporte lot of questions. Th "they would have to R134 said RN-B did that and go through R134 said she had they were answered Questions such as: used? Am I suppose walker? Am I suppose was held at lap leve was hard to see the couldn't truly review	 /14/16, at 1:59 p.m. R134 hitted on a Monday and it was 4 stated they were greeted by the referral packet from the ed she had surgery on her a registered nurse. n in the day she was admitted, e asked about her instructions, ictions, assistance needed, game plan was". R134 stated e interagency packet or get a id it was very awkward in a public area and she was she knows it was her right to mation, and said so at the R134, the unidentified staff what exactly are you asking d she replied, she just had a e staff person then told her, check on that." I come in another day after the chart with her, however, questions and didn't feel that I by RN-B, even at that time. Why isn't a gait belt being ed to use a wheelchair or a posed to have assistance when ontinued to state the chart I, so with her neck brace on, it chart and she felt that she it. 	F 1	54			
	medications she did	nen she received her I not recognize them all and ed staff person what "the little					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/13/2016

FORM APPROVED

	TMENT OF HEALTH RS FOR MEDICARE								RINTED: FORM MB NO.	APPRO	OVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUI IDENTIFICATIO	PLIER/CLIA	1 · ·		LE CONSTRUCT	ION		(X3) DATE		EY
		2454	91	B. WING	;				04/1	4/201	6
NAME OF	PROVIDER OR SUPPLIER			•		STREET ADDRES					
AUGUS ⁻	TANA MERCY CARE C	ENTER				710 SOUTH KE		IUE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIE (MUST BE PRECEDE SC IDENTIFYING INFO	D BY FULL	ID PREF TAG		(EACH	CORRECTIVE A	DF CORRECTIO CTION SHOULE O THE APPROP NCY)	BE	(XE Compli Dat	ETION
F 154	Continued From pa white pill" was. The did not know and w R134 said it was "fr someone who didn' said they told her la stomach acid). To couldn't tell R134 w why. R134 said she had not to take pills with However, sometime crushed, and other R134 said there wa interagency paperw assistance in the fa transferring herself stay, but she never recommendations v In an interview on 4 stated there were di received from the re she had to call the r many times to get th RN-B stated she did room and review it v stated she told FM- the referring hospita Referral Form. RN-B stated R134 v time of admission a R134 was an assist walker. In an interview on 4.	e staff person rep ould have to che reaky" to take pill t know what they ter that it was jus further her frustra- then they were pill a swallow study out them being of es she was gettir times not. s a discrepancy rork and the implicitity. R134 state and had been th knew what the was from the hos /14/16, at 2:19 p iscrepancies in the eferring hospital. referring hospital. referring hospital. the correct orders d bring R134's ch with her. However B that they would al for a copy of the was self-transferring nd the paperwor of 1 with front w /14/16, at 2:42 p	ck on it. s from were. R134 st Pepcid (for ation, staff rescribed or and was told crushed. g pill between the ementation of ed she was roughout her pital. .m., RN-B he paperwork RN-B stated and clinic hart to her er, RN-B t have to call e Interagency ring at the k indicated heeled		154	cility ID: 00049		If continua	tion sheet	Page 4	of 17

		AND HUMAN SERVICES & MEDICAID SERVICES			FOI	ED: 05/13/2016 RM APPROVED IO. 0938-0391	
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) I	(X3) DATE SURVEY COMPLETED	
		245491	B. WING	÷		04/14/2016	
NAME OF	PROVIDER OR SUPPLIER	······································		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	TANA MERCY CARE C	ENTER			10 SOUTH KENWOOD AVENUE IOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 154	stated she asked a shower nearby, as s bath or shower. R1 with no other inform someone told her b wondered why som don't know, but let r know; or, would you R134 said the staff, seem to know what everyone kept askir she had no idea. R planning a care con involved in her care 483.15(a) DIGNITY INDIVIDUALITY The facility must pro- manner and in an er enhances each resi full recognition of his This REQUIREMEN by: Based on observatir review, the facility fa dining experience in In addition, the facili maintained during p residents (R12) revi	staff person if there was a she hadn't been asked about a 34 reported she was told "no", ation. A day or so later ath days are Tuesdays. R134 eone couldn't have said, "I ne find out and I'll let you like to have a shower today?" including the therapists, didn't the plan was for her, and og her the "game plan", but 134 said even though they are ference, she did not feel AND RESPECT OF omote care for residents in a nvironment that maintains or dent's dignity and respect in s or her individuality. IT is not met as evidenced on, interview and document illed to ensure a dignified 1 of 2 resident dining rooms. ty failed to ensure dignity was ersonal cares for 1 of 3	F 1	241	F241;It is the policy of Augustana Mercy Health care center to ensure that dignity provided for all residents at all times. Al 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	is I	

Facility ID: 00049

If continuation sheet Page 5 of 17

		AND HUMAN SERVICES	• ···· ··			FORM	: 05/13/201 APPROVE . 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245491	B. WING	i		04/14/2016	
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUS	TANA MERCY CARE C	ENTER			710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 241	tables in the facility room full of residen tables visiting. App residents had been were sitting with be By 6:11 p.m., appro had been served th continuing to bring f 6:13 p.m., nursing a between dining roor stated to a staff per don't feed the feede residents, including assistance with thei this statement. In an interview on 4, again stated they fe confirmed she had of residents who need NA-A agreed it may for a person. In an interview on 4, director of nursing (expect staff not to u reference to resider "don't want staff to b R12 felt bad when co use the commode. If behind a curtain and visitors. In addition, window while she w can have "fresh air". R12's face sheet inc	dining room. In addition to a ts, 3 family members were at roximately half of the served dinner, and the others verages. ximately half of the residents eir meal and staff were food out for the residents. At assistant (NA)-A, was walking m tables to the kitchen and son following behind her, "We ers until last." Several tables of residents who needed r meal, were within earshot of /11/16, at 6:20 p.m., NA-A ed "feeders" last. NA-A used that word to describe ed assistance with eating. not be a respectful reference /14/16, at 1:43 p.m., the DON) stated she would se the term "feeder" in its. The DON stated they, be saying that." hided for her frequent need to R12 used a commode just d at times her roommate had staff would open R12's as on the commode so they	F2	241	was offered to resident. Resident ar daughter agreeable to private room resident moved on 5/11/16. No other resident's in the facility use a comm and have a roommate at this time. If future RN staff will address need for commode use in a shared room in the bowel and bladder assessments that completed upon admission, quarter with significant change. Staff will tall steps such as asking visitors to exit room while the commode is being us ensure the privacy curtain is closed, consider private room arrangements is identified through the assessment resident needs to use a commode we residing in a shared room the DON of ADON will be notified and alternative options will be reviewed such as a p room if necessary. All bowel and bla assessments will be reviewed to ensu- that there are no further privacy issu- regards to toileting. To ensure compliance; the Dietary Director or designee will complete five random room audits weekly for 4 weeks ther monthly for 3 months to ensure compliance with results being review the quality assurance committee to determine further compliance needs DON or designee will complete five random audits of personal cares pro 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 5/1	and er ode n the heir at are y and ke the se, and s. If it that a vhile or erivate adder sure les in dining n five ved by . The vvided ve	

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 05/13/2016 APPROVED . 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245491	B. WING	;		04	14/2016	
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
AUGUST	ANA MERCY CARE C	ENTER			710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 241	kidney disease. R12's Physician Orc indicated R12 receiv Lasix, a diuretic, twi 12:00 noon. R12's quarterly Mini 2/16/16, indicated R impairments in cogr bladder and bowel, or behaviors. R12's toileting care R12 was to be toilet to 11:30 a.m. (lunch R12 maintain bladde In an interview on 4/ stated staff don't alw and dignity. R12 sta staff to answer her of go, she had to go. F staff would come to and say they would they didn't return. R put her call light on a In an observation or p.m., R12 and her ro The roommate had came on and two sta at 12:59 p.m. At 1:0 back on. At 1:17 p.r room and shut the d roommate and visitor	muscle weakness and chronic der Report, dated 4/14/16, ved 40 milligrams (mg) of ce a day, at 8:00 a.m. and mum Data Set (MDS), dated 12 had moderate hition, was always continent of and had no signs of delirium plan, dated 2/22/16, indicated ed every two hours and prior). The goal indicated to have er continence on the day shift. /11/16, at 4:04 p.m., R12 vays treat her with respect ted she waited and waited for call light, and when she had to R12 continued to explain the the door, turn off the call light return in a few minutes, but return in a few minutes, but return in a few minutes, but return and the would have to again. n 4/13/16, beginning at 12:57 commate were in their room. a male visitor. R12's call light aff responded with a Hoyer lift 09 p.m., R12's light came m., two aides entered the loor. At 1:21 p.m., R12's or exited the room and went to 24 p.m., R12 was sitting in her	F 2	241				

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391			
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
i		245491	B. WING			04/	14/2016			
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE					
AUGUST	ANA MERCY CARE C	ENTER		710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767						
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE			
F 241	Continued From pa	ge 7	F 2	241						
	assistant (NA)-F sta the bedroom becau transfers and there move around the ro NA-F showed her g indicated R12's use In a telephone inter- a.m., family member told that they can't g bathroom so R12 us bedroom. FM-A sta commode when R12 FM-A stated R12 has the staff don't ask th leave. FM-A stated the window for "fres commode. FM-A al air blew right on R12 commode. FM-A al air blew right on R12 commode. FM-A at use of the commode commode at care co cleanliness of the co not the privacy and FM-A also stated R2 urinate and she wor FM-A had observed and say, "You just w was a limit on the nu use the commode. In an interview on 4/ stated that while the residents should has	 /13/16, at 1:32 p.m., nursing ated R12 used a commode in se she needed a Hoyer lift for was not enough room to ommate into the bathroom. roup sheet where she had of the commode at 1:16 p.m. view on 4/14/16, at 10:13 or (A) stated they have been get the Hoyer lift into the sed a commode in the ted it's an issue of using the 2's roommate has company. It is to sit behind the curtain and be roommate's company to the staff will at times, open h air'' while R12 used the so stated when staff did that, 2 while she is sitting on the ated they have brought up the e and the cleanliness of the ommode was addressed, but dignity issues. 12 has frequent urges to ried about "wetting herself". the staff answer R12's light rent". FM-A wondered if there umber of times a resident can (14/16, at 11:04 a.m., R12 curtain did get pulled, ve a little more privacy. R12 bathroom privileges, now that but she "can't help it." R12 								

Facility ID: 00049

If continuation sheet Page 8 of 17

		AND HUMAN SERVICES				APPROVE
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COMPI	
		245491	B. WING		04	/14/2016
NAME OF	PROVIDER OR SUPPLIER	Second Contractions and Contraction Contractions		STREET ADDRESS, CITY, STATE, ZIP	CODE	
AUGUST	TANA MERCY CARE C	ENTER	1	710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 241	and they're "so sno In an interview on 4 registered nurse (R staff would ask the while a resident is u reiterated that staff to step out for a few a dignity issue for re got frustrated with s residents who have she educated staff t "go less", you have she explained to sta not a behavior and to can't go.	d her she's not the only one tty". /14/16, at 11:42 a.m., N)-A stated she hoped that visitor to step out of a room using the commode. RN-A should ask family and visitors winutes. RN-A stated it was esidents. RN-A continued she staff who were frustrated with urge issues. RN-A stated that you can t make someone to assist them. RN-A stated aff that an urge to urinate is they can't tell a resident they	F 247			
F 258 SS=D	but not received. 483.15(h)(7) MAINT COMFORTABLE SC	OUND LEVELS	F 258			5/24/16
	by: Based on observative review, the facility factorial sound levels for 1 of for dignity. Findings include:	IT is not met as evidenced ion, interview, and document ailed to ensure comfortable f 3 residents (R12) reviewed dicated diagnoses which		F258; It is the policy of Augustana Care Center to ensure com levels for all residents. The daughter were interviewed 5/10/16 and offered private Resident and daughter agro change. Resident moved to	fortable sound resident and again on room. eed to room	

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		E SURVEY	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AUGUSTANA MERCY CARE CENTER 710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767 MOOSE LAKE, MN 55767 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECT) DATE SURVEY COMPLETED	
AUGUSTANA MERCY CARE CENTER 710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767	04/	14/2016	
AUGUSTANA MERCY CARE CENTER MOOSE LAKE, MN 55767 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECT			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORREC			
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHO TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPF DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
F 258 Continued From page 9 included frequency of micturition (frequent need to urinate), muscle weakness and chronic kidney disease. F 258 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. F 258 R34's quarterly MDS dated 2/27/16, indicated R34's quarterly MDS dated 2/27/16, indicated R34's quarterly MDS dated 2/27/16, indicated R34's quarterly 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. Will be developed to identify toportium or behavior symptoms directed toward others (threatening, screaming, or cursing at others). The MDS indicated R34 had mild symptoms of depression. Will be developed to identify toportium or seident/responsible party will be a copy of the handbook and the noise levels and identify toporting resident toward others (threatening, screaming, or cursing at others). The MDS indicated R34 a.m., R34's TV was on and could be heard in the haliway. ST 4: acility staff including staff were re-educated on 4/21/1 the process for reporting resident concerns including reporting resident concerns including reporting resident concerns including reporting resident should be clearly heard two rooms away. During an observation on 4/14/16, at 11:36 a.m., R34's TV was on and loud; R34 was dozing in her wheelchair. Staff were resident in turning it down to a comfortable level and then repor concern to a supervisor immedit facility will provide head phones resident who need to or wish to eadressed per policy as soor are reported and or identified by	ound cerns ley occur. are no All e parties outlines is in the lve noise. duction tatus of nities for ne provide concern o be front line 6 about t mmate educated ectronic learly n request le tely. The for listen to olumes. gs erns levels will as they staff	Page 10 of 17	

	IDENTIFICATION NUMBER:		LE CONSTRUCTION		e survey Pleted
	245491	B. WING		04/	14/2016
NAME OF PROVIDER OR SUP		7	STREET ADDRESS, CITY, STATE, ZIP CODE 710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767	1	
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
Notes from the encouraged to with lowering ti turn down TV H During an inter stated R34's T stated sometim R12 continued too early. R12 R34 wanted it, she asked R34 roommate wou loud TV drove but she doesn said she used f anymore. R12 said she h isn't anything th In an interview member (FM)-// the TV volume years ago. FM conference, the in between time turned down bu last time FM-A R34's right to h a problem with room. FM-A sta and made R12 stated sometim couldn't talk; the visit.	onference on 9/8/15 and 3/10/15. 9/8/15 conference read, "Resident update staff so staff can assist ne TV volume and roommate to	F 258	along with, additional follow up at Conferences the resident/respon- party will be asked if there are an concerns that the resident may had Concerns will be addressed per p The DON or designee will compler random audits per week of sound for 4 weeks and then five per mon months to ensure compliance. A will be reviewed by the facility qua assurance committee to determin compliance needs. Corrected by	sible y ave. olicy. ete five levels oth for 3 l results ality e further	

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

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION		E SURVEY IPLETED
		245491	B. WING	i		04/	14/2016
	PROVIDER OR SUPPLIER	ENTER		7	STREET ADDRESS, CITY, STATE, ZIP CODE 710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 258	nothing they could of hard to watch R12 of sometimes the staff and they would eve morning in order to In an interview on 4 stated there's, "noth said R34 sat and sle R12 indicated it was went to bed so early R12 stated she's no grumble. R12 pulled wiping tears from he different, but I can't better make up my ended by saying, "I's everybody, but not a In an interview on 4, social worker (SW)- on all day and often was a resident's righ level. SW-A stated headphones to acco some residents are said they talked abo can do about it." SW headphones and R1 SW-A stated she wo walking by and they same (when the roo However, SW-A also	A stated they felt there was do. FM-A stated it was very cry, at her age. FM-A stated f are flip about R12's concern in turn on R34's TV in the catch the morning shows. /14/16, at 11:04 a.m., R12 ning I can do about it". R12 ept all day with the TV blaring. Is her own fault because she /. thappy, but she shouldn't d out a handkerchief, and er eyes said, "I wish it were do anything about it so I mind I'm going to like it." R12 ve always gotten along with anymore." /14/16, at 11:51 a.m., the A confirmed R34 had her TV very loud. SW-A stated it in to have the TV on at their some residents use ommodate roommates, but not willing to do that. SW-A out it, but "there's not much we V-A stated R34 has refused I2 won't move from the room. ould turn down the TV when encouraged aides to do the immate is sleeping). to stated R34 was completely her right to have the TV on. ad not talked to the	F 2	258			

		AND HUMAN SERVICES				FORM	05/13/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD			(X3) DATE SURVEY COMPLETED	
		245491	B. WING	<u> </u>		04/	14/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA MERCY CARE C	ENTER			10 SOUTH KENWOOD AVENUE 100SE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465 F 465 SS=E	483.70(h) SAFE/FUNCTIONA E ENVIRON The facility must pro- sanitary, and comfor residents, staff and This REQUIREMEN by: Based on observat review, the facility fa unconsumed food it not provide a clean environment for 1 o for nutrition. In add ensure ensure walls properly maintained home-like environm (201, 205, 308, 310 reviewed for enviror Findings include: On 4/12/16, at 2:01 observed on a table	AL/SANITARY/COMFORTABL by ide a safe, functional, ortable environment for the public. AT is not met as evidenced ion, interview, and document ailed to ensure collection of tems on meal trays which did and pleasant room f 3 residents (R106) reviewed ition, the facility failed to s, doors, and floors were to provide a cleanable and ent in 8 of 30 resident rooms , 312, 315, 317, and 407)	F 4 F 4		F465 It is the policy of Augustana I Health Care Center to ensure a clear pleasant environment in the facility. tray was removed from resident R10 soon as the error was noted. All sta be educated on importance of pickin meal trays within two hours of the m served. A new procedure for trackin room trays being delivered and pick will be implemented. The DON or a designee will audit room tray pass of residents per week for 4 weeks and 5 residents per month for 3 months results being reported to Quality assurance committee to determine compliance needs. Staff education provided on 4/21/16 regarding need	an and Meal 06 as ff will ng up neal ng ded up then with further was	5/24/16
	dome which covere including: a scramb and toast. Upon ent an obvious, foul odd tray was delivered to 7:00 a.m., (7 hours forgot to come back food, then stated, th	d unconsumed foods led egg, two pieces of bacon ering R106's room there was or. R106 reported the meal o her room on 4/12/16 around earlier). R106 reported staff to the room to pick up the breakfast food on the tray pleasant smell in the room all			report all maintenance concerns in r as soon as they are noted. Mainten staff has made all necessary repairs the rooms outlined in the 2567 repo Audits will be made of all resident ro and repairs will be completed. 10 ro maintenance audits will be complete monthly with Maintenance Director a reported to QA Administrator for rev Corrected by 5/24/15	rooms aance s to rt. ooms oom ed and	

Facility ID: 00049

If continuation sheet Page 13 of 17

		AND HUMAN SERVICES					FORM	05/13/2016 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		NSTRUCTION		(X3) DATE	E SURVEY PLETED
		245491	B. WING				04/1	4/2016
NAME OF	PROVIDER OR SUPPLIER			STREE	TADDRESS, CITY, STATE, ZIP C	ODE	<u> </u>	
AUGUST	TANA MERCY CARE C	ENTER			OUTH KENWOOD AVENUE SE LAKE, MN 55767			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 465	On 4/12/16, at 2:28 observed collecting resident rooms, R11 in the room on the t On 4/12/16, at 2:44 reported the nursing pick up the meal tra- wish to eat in their r NA-A reported she w member delivered t Upon request, NA-A R106's room. NA-A the plate to identify that stinks." NA-A of toast were served in have been picked u On 4/12/16, at 2:47 (LPN)-A reported th pass and pick up all reason the staff cour would communicate stated that was not she worked the unit LPN-A stated R106 delivered on 4/12/16 not removed until re Review of the Augus Dining Menu Dated was a cheese omele On 4/13/16, at 8:00 ambulate independe was able to eat and On 4/13/16, at 8:40	p.m. a staff member was lunch trays from other 06's breakfast tray remained table. p.m. nursing assistant (NA)-A g assistants are to pass and ays for those residents that oom, then document intakes. was unsure which staff he breakfast tray to R106. A removed the meal tray from A lifted the plastic dome off of the food items and stated, "oh confirmed the eggs, bacon and n the morning and should	F	465				
FORM CMS-25	67(02-99) Previous Versions			Facility ID:	00049 If co	ontinuatio	n sheet Pa	age 14 of 17

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE					FORM	: 05/13/2016 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	245491	B. WING	G		04/	14/2016
NAME OF PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUSTANA MERCY CARE C	ENTER			710 SOUTH KENWOOD AVENUE		
			1	MOOSE LAKE, MN 55767		1
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
on the plate which in hash brown triangle the plate, the french triangle was brough had been there even never came to get if am invisible in here. On 4/13/16, at 8:59 nurse (RN)-A remove room. RN-A confirm brown triangle were supper (15 hours eas leaving meals in rest acceptable; the tray On 4/14/16, at 9:31 (DON) confirmed th have a system in pla collection of meal transformed to have a system in pla collection of meal transformed th have a syste	There was unconsumed food ncluded french toast and a R106 reported the food on a toast and hash brown it in last night for supper and r since. R106 stated staff t, then "I guess the staff think I " a.m. upon request, registered wed the meal tray from R106's ned the french toast and hash served the previous day for arlier). RN-A further stated sident rooms was not should have been collected. a.m. the director of nursing e facility currently did not ace to track the delivery and ays. The DON then stated we etter system to ensure all octed in a timely manner. Service policy, dated 4/14 s would be removed from the 12 hours after meal delivery. D a.m. the maintenance following: was build-up of dark debris/dirt the floor. was build-up of dark edges of the floor.		465		ion sheet	Page 15 of 17

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

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245491	B. WING	G		04/	/14/2016
NAME OF PROVIDER OR SUPPLIER AUGUSTANA MERCY CARE CENTER		1	7	STREET ADDRESS, CITY, STATE, ZIP CODE 710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 465	bathroom door fram room heat register v -Room 310: The ba curling up on the ba black marred areas word "window" was wall paper. The ba right of the bathroom broken off. The heat marred. -Room 312: The pa sink was cracked at and was not cleana bathroom door was bare wood. The heat marred. The mainta sink needed to be marred. The mainta sink needed to be marred. -Room 315: The in bathroom doors we down low, exposing the door were badly edges. The bathroom The heat register was maintenance director needed to be replaced -Room 317: The in badly scraped, expo -Room 407: The bathroom the toilet. There were The bathroom wall the 'The maintenance director	he was scratched and the was scraped. The was scraped. The was scraped. The written in black letters on the seboard on the corner to the m door had a large piece at register was scraped and the ridges were easily felt ble. The inside of the deeply scratched, exposing at register was scratched and enance director stated the eplaced. Side of the room and the re badly gouged, up high and bare wood, and the edges of nicked, causing rough, sharp om door frame was scratched. as scratched. The or stated the bathroom door ced.	F	465			

FORM CMS-2567(02-99) Previous Versions Obsolete

	IMENT OF HEALTH		FORM APPROVE OMB NO. 0938-03				
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION	(X3) DA1	TE SURVEY MPLETED
		245491	B. WING	;		04	/14/2016
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
	ANA MERCY CARE C	ENTER		· ·	10 SOUTH KENWOOD AVENUE		
				r	MOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 465	were done in each concerns had not b rounds or by staff. The Monthly Quality 3/14/16, lacked idea concerns identified The undated Month indicated the doors	-	F 4	465			
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: PE4L11		Fa	cility ID: 00049 If continua	tion sheet	Page 17 of 17

PRINTED: 05/13/2016 FORM APPROVED

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		TE SURVEY
		245491	B. WING		04	/12/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA MERCY CARE C	ENTER		710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	S	K 00	00		
	FIRE SAFETY					
	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.			8	
	ONSITE REVISIT C CONDUCTED TO V SUBSTANTIAL COI REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE /ALIDATE THAT MPLIANCE WITH THE .S BEEN ATTAINED IN TH YOUR VERIFICATION.				
	Minnesota Departm Fire Marshal Divisio Augustana Mercy C substantial compliar participation in Medi Subpart 483.70(a), I 2000 edition of Natio Association (NFPA)	Survey was conducted by the ent of Public Safety, State n. At the time of this survey, are Center was found not in nce with the requirements for icare/Medicaid at 42 CFR, Life Safety from Fire, and the onal Fire Protection Standard 101, Life Safety er 19 Existing Health Care.			7	
	DEFICIENCIES (K	R THE FIRE SAFETY TAGS) TO: E INSPECTIONS		EPOC		
	STATE FIRE MARS 445 MINNESOTA S ST. PAUL, MN 5510	TREET, SUITE 145				-

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.

ATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		0. 0938-039 TE SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A BUILDING 0	CO	COMPLETED	
		245491	B. WING		04	/12/2016
AME OF I	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP COD	ЭE	
AUGUST		CENTER		0 SOUTH KENWOOD AVENUE OOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
K 000	Continued From pa	age 1	K 000			
	By e-mail to both: Marian.Whitney@s and	state.mn.us				
	Angela.Kappenma	n@state.mn.us				
		RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION:				
	1. A description of to correct the defic	what has been, or will be, done iency.				
	2. The actual, or pr	oposed, completion date.				
	responsible for cor	or title of the person rection and monitoring to ence of the deficiency			181 18 19	
	building with small building was constructed in 196 constructed in 196 construction). A sin nursing home and To the south a sing living facility also a hour construction v	Care Center is a 1-story partial basement. The original ructed in 1964 and additions 8 and 1977, all of Type II(111 ngle story hospital adjoins the is separated by a 4 hour wall. le story type V(111) assisted djoins and is separated by 4 vith a 3 hour rated, self closing e nursing home was inspected				
	facility has a compl smoke detection in	y sprinkler protected. The lete fire alarm system with the corridors and spaces r, that is monitored for artment notification.				

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	RS FOR MEDICAR	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DAT	E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01 - MAIN BUILDING 01 B. WING			COMPLETED 04/12/2016	
		245491					
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
AUGUS	ANA MERCY CARE	CENTER		10 SOUTH KENWOOD AVENUE IOOSE LAKE, MN 55767			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	OULD BE COMPLETI		
K 000	Continued From p	age 2	K 000				
	had a census of 7	0 at the time of the survey.					
	The requirement a NOT MET.	at 42 CFR Subpart 483.70(a) is					
K 017 SS=C		AFETY CODE STANDARD	K 017			5/15/16	
	rating. In fully sprin partitions are only of smoke. In non-sextend to the under above the ceiling. at the underside of permitted by Code waiting areas, dini may be open to co specified in the Co separated from co if the gift shop is fu 19.3.6.1, 19.3.6.2, This STANDARD Based on observa- revealed that the f in the ceiling tile for in compliance with (00) Sections 19.3 the passage of sm could in the event flames to spread t corridors and area which could negat as well as an under visitors of the facil Findings include:	19.3.6.4, 19.3.6.5 is not met as evidenced by: ations and staff interview, it was acility had penetrations located ocated in the facility that are not nNFPA Life Safety Code 101 6.6.2 and 8.2.4.4.1 in resisting noke. This deficient conditions of a fire, allow smoke and hroughout the effected is making them untenable, ively affect 12 of 66 residents, etermined number of staff, and		K17- holes in wall by kiosk 25 The holes were repaired on 4/28. A hallway walls were examined for penetrations to the walls that may be the smoke barrier. Any holes ident were fixed by 5/15/16. All staff were in-serviced on the process for repor- repair needs on 4/21/15. The Maintenance Director or designee audit the hallway walls on a quarter basis. Items identified will be repair	break tified e orting will rly		

STATEMEN	T OF DEFICIENCIES	E & MEDICAID SERVICES	· · /) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01 - MAIN BUILDING 01	04/12/2016		
		245491	B. WING				
NAME OF	PROVIDER OR SUPPLIER	1.	STREET ADDRESS, CITY, STATE, ZIP CODE				
AUGUST	TANA MERCY CARE	CENTER		10 SOUTH KENWOOD AVENUE IOOSE LAKE, MN 55767			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)			
K 017		age 3 eter holes in the corridor wall by just above the wall mounted	K 017				
K 029 SS=C	Maintenance Supe NFPA 101 LIFE SA One hour fire rated fire-rated doors) of extinguishing syste and/or 19.3.5.4 pro the approved auto option is used, the	dition was verified by a ervisor. AFETY CODE STANDARD d construction (with o hour r an approved automatic fire em in accordance with 8.4.1 otects hazardous areas. When matic fire extinguishing system areas are separated from noke resisting partitions and	K 029		5/24/16		
	doors. Doors are field-applied protect 48 inches from the permitted. 19.3. This STANDARD Based on observat facility failed to mat barrier walls constit requirements of NI Code" 2000 edition 8.3. This deficient residents, as well a staff, and visitors b	self-closing and non-rated or ctive plates that do not exceed bottom of the door are		The gap was repaired on 4/21/16. All smoke barrier doors were examined f gaps greater than ¼" Any holes identi were fixed by 5/24/16. The Maintenan Director or designee will audit the hall walls on a quarterly basis. Items ident will be repaired.	fied ce way		
	04/12/2016, observed double door to the area that is also op	ween 9:00 AM to 1:00 PM on vations revealed that the loading/receiving dock is in an ben to a soiled linen room has a /4 of an inch between the door		a. A			

ULNIL	KS FOR MEDICARE	E & MEDICAID SERVICES				0938-039	
	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DPLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245491	B. WING		04/	04/12/2016	
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP			
AUGUST	TANA MERCY CARE	CENTER		710 SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIOI DATE	
K 029	Continued From pa	age 4	К 0	029			
	This deficient cond Maintenance Supe	lition was verified by a rvisor.					
K 051 SS=C		FETY CODE STANDARD	K 0	51		4/28/16	
	accordance with N and NFPA 72, Natio provide effective w building. Fire alarn transmission paths Initiation of the fire means and by any alarm, detection de Manual alarm boxe egress near each r boxes in patient sle required at exits if r located at all nurse notification is provid signals. In critical c sufficient. The fire alarm automatically the event of fire. Th activates required of records are mainta 18.3.4, 19.3.4, 9.6 This STANDARD i Based on observat revealed that the fai manually actuated throughout the facil NFPA 101 "The Life (LSC) sections 19.3 National Fire Alarm and 2-8.2, and the This deficient condi	ved for the purpose in FPA 70, National Electric Code onal Fire Alarm Code to arning of fire in any part of the n system wiring or other are monitored for integrity. alarm system is by manual required sprinkler system evice, or detection system. es are provided in the path of equired exit. Manual alarm beeping areas shall not be manual alarm boxes are 's stations. Occupant ded by audible and visual are areas, visual alarms are alarm system transmits the y to notify emergency forces in he fire alarm automatically control functions. System ined and readily available. s not met as evidenced by: tion and staff interview it was incility failed to correctly install alarm-initiating devices ity in accordance with the e Safety Code" 2000 edition 3.4.2 and 9.6.2, NFPA 72 Code (99), Sections 2-8.1 MN State Fire Code 907.3.3.1. ition could adversely affect the fire alarm system and delay		The pull box was move/lor appropriate code height or Maintenance Director mea pull boxes and found them compliance. A smoke detector was plac the fire panel on 4/22/16	a 4/28/16. The sured other fire to be in		

CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TE SURVEY	
CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING 01 - MAIN BUILDING 01			
	245491	B. WING		/12/2016	
		7	10 SOUTH KENWOOD AVENUE		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE	
otification in the elegatively affecting in undetermined r indings include: 0n facility tour betw 4/12/2016, observ re alarm box L1M arrier door FD66 tation was mounted evel which is highe	event of an emergency, thus g 20 of 66 residents, as well as number of staff, and visitors. ween 9:00 AM to 1:00 PM on vation revealed that the Manual 12 located by the smoke and the west wing nurses ed at 60 inches above the floor er than the maximum 54 inches	K 051			
his deficient pract faintenance Supe IFPA 101 LIFE SA fire alarm system e, tested, and ma IFPA 70 National I lational Fire Alarm vailable. The syst naintenance and t pplicable requiren .6.1.4, 9.6.1.7, his STANDARD is Based on observa acility failed to inst ystem in accordar	tice was confirmed by the prvisor. NFETY CODE STANDARD in required for life safety shall intained in accordance with Electric Code and NFPA 72 in Code and records kept readily em shall have an approved esting program complying with ment of NFPA 70 and 72. is not met as evidenced by: tion and staff interview, the all and maintain the fire alarm ince with the requirements of	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	
	SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From pro- otification in the e- egatively affecting n undetermined r indings include: On facility tour betw 4/12/2016, observi- re alarm box L1M arrier door FD66 tation was mounter evel which is higher s stated in NFPA his deficient pract laintenance Super FPA 101 LIFE SA fire alarm system e, tested, and ma FPA 70 National I ational Fire Alarm vailable. The system indings include: A to alarm system e, tested, and ma to alarm system e, tested, and ma FPA 70 National I ational Fire Alarm vailable. The system indings include to instend stated on observary indicated to instend system in accordary 000 NFPA 101, So	A MERCY CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 otification in the event of an emergency, thus egatively affecting 20 of 66 residents, as well as n undetermined number of staff, and visitors. indings include: On facility tour between 9:00 AM to 1:00 PM on 4/12/2016, observation revealed that the Manual re alarm box L1M12 located by the smoke arrier door FD66 and the west wing nurses tation was mounted at 60 inches above the floor evel which is higher than the maximum 54 inchess is stated in NFPA 72 (99) his deficient practice was confirmed by the laintenance Supervisor. FPA 101 LIFE SAFETY CODE STANDARD fire alarm system required for life safety shall e, tested, and maintained in accordance with FPA 70 National Electric Code and NFPA 72 ational Fire Alarm Code and records kept readily vailable. The system shall have an approved naintenance and testing program complying with oplicable requirement of NFPA 70 and 72.	Divider or supplier 7 NA MERCY CARE CENTER 10 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 10 Continued From page 5 K 051 otification in the event of an emergency, thus egatively affecting 20 of 66 residents, as well as n undetermined number of staff, and visitors. K 051 indings include: 0 A112/2016, observation revealed that the Manual re alarm box L1M12 located by the smoke arrier door FD66 and the west wing nurses tation was mounted at 60 inches above the floor evel which is higher than the maximum 54 inches s stated in NFPA 72 (99) K 052 his deficient practice was confirmed by the laintenance Supervisor. K 052 FPA 101 LIFE SAFETY CODE STANDARD K 052 fire alarm system required for life safety shall e, tested, and maintained in accordance with FPA 70 National Electric Code and NFPA 72 ational Fire Alarm Code and records kept readily vailable. The system shall have an approved iaintenance and testing program complying with oplicable requirement of NFPA 70 and 72. 6.1.4, 9.6.1.7, his STANDARD is not met as evidenced by: Based on observation and staff interview, the icility failed to install and maintain the fire alarm system in accordance with the requirements of 000 NFPA 101, Sections 19.3.4, and 9.6, as well	DUIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE YA MERCY CARE CENTER TO SOUTH KENWOOD AVENUE MOOSE LAKE, MN 55767 MOOSE LAKE, MN 55767 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Dontinued From page 5 ID otification in the event of an emergency, thus egatively affecting 20 of 66 residents, as well as n undetermined number of staff, and visitors. K 051 Indigs include: ID on facility tour between 9:00 AM to 1:00 PM on 4/12/2016, observation revealed that the Manual re alarm box L1M12 located by the smoke arrier door FD66 and the west wing nurses tation was mounted at 60 inches above the floor rivel which is higher than the maximum 54 inches s stated in NFPA 72 (99) K 052 his deficient practice was confirmed by the laintenance Supervisor. K 052 fire alarm system required for life safety shall e, tested, and maintained in accordance with FPA 70 National Electric Code and NFPA 72 ational Fire Alarm Code and records kept readily valiable. The system shall have an approved iaintenance and testing program complying with pplicable requirement of NFPA 70 and 72. 6.14, 9.6.17, his STANDARD is not met as evidenced by: based on observation and staff interview, the cility failed to install and maintain the fire alarm stem in accordance with the requirements of JOU NFPA 101, Sections 19.3.4, and 9.6, as well	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PE4L21

Facility ID: 00049

If continuation sheet Page 6 of 8

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTIPL			0938-039 SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		01 - MAIN BUILDING 01	COM	PLETED
		245491	B. WING		04/12/2016	
NAME OF	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA MERCY CARE	CENTER		10 SOUTH KENWOOD AVENUE NOOSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
K 052	Continued From pa	ige 6	K 052			
	Findings include:					
	04/12/2016, observ where the facility's	veen 9:00 AM to 1:00 PM on vations revealed that the room fire alarm control panel is otected by smoke detection.				
K 056 SS=D	Maintenance Supe	ition was verified by a rvisor. FETY CODE STANDARD	K 056	- vC		5/24/16
	facilities shall be pr approved, supervis in accordance with systems are equipp switches which are the building fire ala construction, altern shall be permitted t protection in specifi regulations prohibit NPFA 13 This STANDARD is Based on observat system is not instal accordance with N/ Installation of Sprin The failure to maint compliance with N/ being place out of s the fire protection s of an emergency th	section 19.1.6, Health care otected throughout by an ed automatic sprinkler system section 9.7. Required sprinkler bed with water flow and tamper electrically interconnected to rm. In Type I and II ative protection measures o be substituted for sprinkler c areas where State or local sprinklers. 19.3.5, 19.3.5.1, s not met as evidenced by: ions, the automatic sprinkler led and maintained in APA 13 the Standard for the kler Systems 1999 edition. ain the sprinkler system in APA 13 (99) could allow system service causing a decrease in ystem capability in the event at could affect 66 of 66 s an undetermined number of		The mission escutcheon ring identifives replaced on 4/18/16. All sprinkles heads were examined. Any identified missing escutcheon rings were replated by 5/24/16. If ceiling work or sprinkles work is performed. The Maintenance Director will inspect the area once the work is completed to ensure all escutcheon rings are in place. The glocated on the main fire sprinkler risk replaced and inspected on by 5/24/17 The replacement has been placed on preventive maintenance calendar for	er d aces er e gauge er was 6. n the	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PE4L21 Facility ID: 00049

If continuation sheet Page 7 of 8

		AND HUMAN SERVICES				FORM	05/06/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION - Main Building 01		E SURVEY PLETED
		245491	B. WING			04/	12/2016
NAME OF I	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	ANA MERCY CARE O	CENTER			SOUTH KENWOOD AVENUE OSE LAKE, MN 55767		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 056	Continued From pa	age 7	ĸ	056			
	04/12/2016, observ	veen 9:00 AM to 1:00 PM on rations reveled the following affecting the facility's fire		-			
		utcheon ring missing from the ted at the west wind nurses					
	fire sprinkler riser w	s located on the facility's main vas last tested or replaced on t every 5 years as required by ode.					
	This deficient pract Maintenance Super	ice was confirmed by the rvisor.					
	67(02-99) Previous Versions	Obsolete Event ID: PE4L2	1	Facility	ID: 00049 If contin	uation shee	et Page 8 of 8



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 <u>only a suggestion</u> 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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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

Augustana Mercy Care Center April 28, 2016 Page 2

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 Augustana Mercy Care Center April 28, 2016 Page 3

Minneso	ota Department of He	alth				
-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00049	B. WING		04/1	4/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AUGUST	TANA MERCY CARE C	ENTER	H KENWOO AKE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defict herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 05/05/16

Electronically Signed STATE FORM

If continuation sheet 1 of 23

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00049	B. WING		04/	04/14/2016	
IAME OF I	PROVIDER OR SUPPLIER		T ADDRESS, CITY, ST	TATE, ZIP CODE			
UGUST	ANA MERCY CARE (TENTER	OUTH KENWOOD SE LAKE, MN 557				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro completion date, th corrected prior to e Minnesota Departn On April 11, throug this Department's s and the following c Please indicate in y correction that you	h April 14, 2016, surveyors staff, visited the above provi orrection orders are issued. your electronic plan of have reviewed these orders	for for ne of der				
	Minnesota Departn the State Licensing federal software. Ta	e when they will be complet nent of Health is documentin Correction Orders using ag numbers have been sota state statutes/rules for					
	column entitled "IE statute/rule out of c "Summary Stateme and replaces the "T correction order. The findings which are after the statement evidence by." Follo	number appears in the far le D Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statu t, "This Rule is not met as wing the surveyors findings Method of Correction and rrection.	•				
	FOURTH COLUM "PROVIDER'S PLA APPLIES TO FEDE	ARD THE HEADING OF TH N WHICH STATES, AN OF CORRECTION." TH ERAL DEFICIENCIES ONLY IR ON EACH PAGE.	IS				

Minnesota Department of	Health			RM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			OATE SURVEY OMPLETED
	00049	B. WING		04/14/2016
NAME OF PROVIDER OR SUPPLI	ER STREET AD	DRESS, CITY,	STATE, ZIP CODE	
AUGUSTANA MERCY CAR	E CENTER	TH KENWOO AKE, MN 5		
(X4) ID SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PRÉFIX (EACH DEFICIE	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETE DATE
2 000 Continued From	page 2	2 000		
PLAN OF CORF	EQUIREMENT TO SUBMIT A RECTION FOR VIOLATIONS OF ATE STATUTES/RULES.			
2 555 MN Rule 4658.0 Plan of Care; De	405 Subp. 1 Comprehensive velopment	2 555		5/11/16
must develop a each resident wi completion of the assessment as o comprehensive by an interdiscip attending physic responsibility for appropriate staff the resident's ne practicable, with	evelopment. A nursing home comprehensive plan of care for thin seven days after the e comprehensive resident defined in part 4658.0400. The blan of care must be developed linary team that includes the ian, a registered nurse with the resident, and other in disciplines as determined by eds, and, to the extent the participation of the resident, gal guardian or chosen			
by: Based on intervi facility failed to e (R134) received that was undersi that was most us Findings include R134's face she included cervica due to compress	et identified diagnoses that radiculopathy (damage to nerve sion in the cervical vertebra), on) of the cervical vertebra,		F154; It is the policy of Augustana Merce Health Care Center to fully inform residents in advance about changes of 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 ha no further concerns. On 4/15/16 facility social worker met with resident R134 an provided her with the medical records consent form the resident was provided with instructions on how to request copil of her medical record. All facility staff	n 4 1 d

6899

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		00049	B. WING		04/14/2016	
AME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
UGUST	ANA MERCY CARE O	:ENTER	H KENWO AKE, MN 5	OD AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLE DATE
2 555	Continued From pa	age 3	2 555			
	cognitively intact ar care decisions. In an interview on 4 member (FM)-B sta to the facility, they f incorrect. FM-B sa (RN)-G if they could and they were refus (RN-G was unavail told them once an in hands it is the facilit FM-B stated they h medications, amoun recommended, and did not feel that the questions in a time R134 could unders a good thing he was cares for R134 dur in the facility. In an interview on 4 director of nursing talked to families of The DON stated re their medical record	ad questions about R134's		were re- educated on 4 // procedure for addressing medical records requests resident requests their m All staff that assist in care plans will be educated or inform residents in advar changes on their care an Care Conferences the resident/responsible part they have been informed changes to their care and explanation was understa DON or designee will cor random audits per week then five per month for 3 compliance. All results w the facility quality assurar determine further complia Corrected by 5/11/16	concerns and in the event a edical records. and treatment the need to fully nee about any d treatment. At y will be asked if in advance about d if the andable. The nplete five for 4 weeks and months to ensure <i>i</i> ll be reviewed by nee committee to	
	content. If a reside wants a copy, the f form to sign. In an interview on 4 stated she was adr a rough start. R13	a them to interpret the medical ent or their power of attorney acility has a standard consent 4/14/16, at 1:59 p.m. R134 nitted on a Monday and it was 4 stated they were greeted by r the referral packet from the				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00049	B. WING		04/	04/14/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
	ANA MERCY CARE C	TIO SOU		D AVENUE			
AUGUSI		MOOSE L	AKE, MN 55	767			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 555	Continued From pa	ige 4	2 555				
		ted she had surgery on her					
	or the next day, she appointments, restr basically what the " she asked to see th copy of it. R134 sa because they were told no. R134 said see her health infor time. According to person asked her " for?". R134 reports	n in the day she was admitted, e asked about her instructions, rictions, assistance needed, game plan was". R134 stated he interagency packet or get a id it was very awkward in a public area and she was she knows it was her right to rmation, and said so at the R134, the unidentified staff what exactly are you asking ed she replied, she just had a he staff person then told her, o check on that."					
	that and go through R134 said she had they were answere Questions such as: used? Am I suppos walker? Am I supp I transfer?. R134 c was held at lap leve	d come in another day after the chart with her, however, questions and didn't feel that d by RN-B, even at that time. Why isn't a gait belt being sed to use a wheelchair or a toosed to have assistance when continued to state the chart el, so with her neck brace on, it e chart and she felt that she w it.					
	medications she did asked the unidentif white pill" was. The did not know and w R134 said it was "fr someone who didn said they told her la stomach acid). To	then she received her d not recognize them all and ied staff person what "the little e staff person replied that they rould have to check on it. reaky" to take pills from 't know what they were. R134 ater that it was just Pepcid (for further her frustration, staff then they were prescribed or					

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		00049	B. WING		04/	04/14/2016	
IAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE			
UGUST	ANA MERCY CARE	SENTER	TH KENWOOD LAKE, MN 557				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 555	Continued From pa	age 5	2 555				
	R134 said she had not to take pills witl	a swallow study and was told nout them being crushed. es she was getting pill times not.					
	interagency paperv assistance in the fa transferring herself stay, but she never	as a discrepancy between the vork and the implementation of acility. R134 stated she was and had been throughout her knew what the was from the hospital.					
	stated there were or received from the r	4/14/16, at 2:19 p.m., RN-B discrepancies in the paperwork eferring hospital. RN-B stated referring hospital and clinic the correct orders.					
	room and review it stated she told FM	d bring R134's chart to her with her. However, RN-B B that they would have to call al for a copy of the Interagency	,				
	time of admission a	was self-transferring at the and the paperwork indicated t of 1 with front wheeled					
	stated she asked a shower nearby, as bath or shower. R with no other inform someone told her b wondered why som don't know, but let	4/14/16, at 2:42 p.m., R134 staff person if there was a she hadn't been asked about a 134 reported she was told "no" nation. A day or so later bath days are Tuesdays. R134 neone couldn't have said, "I me find out and I'll let you u like to have a shower today?"					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00049	B. WING		04/	14/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
AUGUST	ANA MERCY CARE C	'ENTER	TH KENWOOD AKE, MN 557			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 555	Continued From pa	ige 6	2 555			
	seem to know what everyone kept askin she had no idea. F planning a care cor involved in her care SUGGESTED MET The Director of Nur develop policies an residents or their re participates in the c comprehensive car could be educated resident/representa of Nursing or her de	THOD OF CORRECTION: rsing or her designee could d procedures to ensure epresentative actively development of a re plan. All appropriate staff				
21426	(21) days MN St. Statute 144	R CORRECTION: Twenty-one	21426			4/25/16
	maintain a compreh infection control pro- current tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide	ntrol e provider must establish and hensive tuberculosis ogram according to the most s infection control guidelines d States Centers for Disease htion (CDC), Division of hation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis an that covers all paid and contractors, students, nteers. The Department of e technical assistance ntation of the guidelines.				

Minneso	ta Department of He	alth				_
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE COMPI	
		00049	B. WING		04/1	4/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
AUGUST	ANA MERCY CARE C	ENTER	TH KENWOO AKE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 7	21426			
	(b) Written complia be maintained by th	ance with this subdivision must ne nursing home.				
	by: Based on interview facility failed to ensitests (TST) were con- Findings include: Licensed practical in- start date was 12/2 first-step TST on 12 received the secon- provided evidence of 90 days prior to dat Nursing Assistant (I was 2/27/16. NA-F 2/23/16. NA-F had TST, and had not p negative TST dated hire. The facility policy a (tuberculosis) Prever revised 2/15, direct would receive a bas an evaluation of ris and testing for the p by either a two-step Employees were to	ent is not met as evidenced and document review, the ure two-step tuberculin skin ompleted for 2 of 5 employees. hurse (LPN)-B's employment 2/15. LPN-B received the 2/16/15. LPN-B had not d-step TST, and had not of a negative TST dated within e of hire. NA)-F's employment start date received the first-step TST on not received the second-step rovided evidence of a d within 90 days prior to date of the procedure for TB ention and Control Guidelines ed all health care workers seline TB screening to include (a factors for active TB disease presence of infection with TB o TST or TB blood test. receive TB screening prior to ding a first step TST.		It is the policy of Augustana Mercy Care Center to ensure that all emp are tested for TB with a 2-step tub skin as required. An audit was co on all employee files to ensure tha employees had the 2-step skin tes other acceptable method of TB tes staff were educated on need to co 2-step process upon hire. A proce was developed for the tracking of employee TB tests. The Human Resources Director or designee w all new employee files as they are the next 3 months to ensure comp with results being reported to QA committee to determine further compliance needs. Corrected by a	bloyees erculin nducted t all t or sting. All mplete dure new ill audit hired for liance	

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY IPLETED	
		00049	B. WING	04	04/14/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
UGUST	ANA MERCY CARE C	'ENTER	TH KENWOO LAKE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE	
21426	Continued From pa	ge 8	21426			
	for Tuberculosis Co Care Settings dated may begin working	partment of Health Regulations ontrol in Minnesota Health d 6/13, directed an employee with patients after a negative n and a negative TST dated re hire.				
	director of nursing (develop systems to staff are completed Disease Control red her designee could on these systems.	HOD OF CORRECTION: The (DON) or her designee could ensure TB screenings for d according to the Center for commendations. The DON or educate all appropriate staff The DON or her designee itoring systems tto ensure e.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One				
21665	MN Rule 4658.1400) Physical Environment	21665		5/24/16	
	functional, comforta environment, allowi	ust provide a safe, clean, able, and homelike physical ng the resident to use s to the extent possible.				
	by: Based on observati review, the facility f unconsumed food i not provide a clean environment for 1 c for nutrition. In add ensure ensure wall	ent is not met as evidenced on, interview, and document ailed to ensure collection of tems on meal trays which did and pleasant room of 3 residents (R106) reviewed lition, the facility failed to s, doors, and floors were d to provide a cleanable and		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		

PE4L11

If continuation sheet 9 of 23

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL		
		00049	B. WING		04/14	04/14/2016	
AME OF F	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY,	STATE, ZIP CODE			
UGUST	ANA MERCY CARE (CENTER	JTH KENWO				
		MOOSE	LAKE, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
21665	Continued From pa	age 9	21665				
	 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. 		s d	room trays being delivere will be implemented. The designee will audit room to residents per week for 4 we residents per month for 3 results being reported to a assurance committee to a compliance needs. Staff provided on 4/21/16 regar report all maintenance co as soon as they are noted staff has made all necess rooms outlined in the 256 will be made of all resider repairs will be completed. maintenance audits will b monthly with Maintenance reported to QA Administra Corrected by 5/24/15	e DON or a tray pass on 5 weeks and then 5 months with Quality determine further education was rding need to oncerns in rooms d. Maintenance sary repairs to the of report. Audits nt rooms and . 10 room e completed e Director and		
	reported the nursin pick up the meal tra- wish to eat in their NA-A reported she member delivered Upon request, NA- R106's room. NA- the plate to identify that stinks." NA-A	4 p.m. nursing assistant (NA)-/ ng assistants are to pass and ays for those residents that room, then document intakes. was unsure which staff the breakfast tray to R106. A removed the meal tray from A lifted the plastic dome off of the food items and stated, "ol confirmed the eggs, bacon an in the morning and should up after breakfast.	h				
nesota De		7 p.m. licensed practical nurse he nursing assistants were to					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00049	B. WING		04/14/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
AUGUST	ANA MERCY CARE	TENTER	TH KENWOOI LAKE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21665	Continued From pa	age 10	21665			
	reason the staff co would communicat stated that was not she worked the un LPN-A stated R10 delivered on 4/12/1 not removed until r Review of the Augu Dining Menu Dated was a cheese ome On 4/13/16, at 8:00 ambulate independ was able to eat and On 4/13/16, at 8:40 bed, a plate with a next to R106's bed on the plate which	III meal trays. If for some uld not complete the task they te that to the nurses. LPN-A t the case today, and confirmed it in which R106 resided. 6's breakfast tray was 16 around 8:00 a.m., and was requested at 2:44 p.m Ustana Mercy Care Center d 4/12/16, identified breakfast elette, bacon, wheat toast. 0 a.m. R106 was observed to dently to the dining room. R106 d drink independently. 0 a.m. R106 was resting on the plastic dome rested on a table . There was unconsumed food included french toast and a	6			
	the plate, the frenc triangle was brough ad been there eve	e. R106 reported the food on h toast and hash brown ht in last night for supper and er since. R106 stated staff it, then "I guess the staff think e."	Γ			
	nurse (RN)-A remo room. RN-A confir brown triangle were supper (15 hours e leaving meals in re	a.m. upon request, registered oved the meal tray from R106's med the french toast and hash e served the previous day for earlier). RN-A further stated sident rooms was not y should have been collected.				
	(DON) confirmed thave a system in p	I a.m. the director of nursing he facility currently did not lace to track the delivery and rays. The DON then stated we				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00049	B. WING		04/	14/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
AUGUST	ANA MERCY CARE	CENTER	JTH KENWOOI LAKE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21665	Continued From pa	age 11	21665			
		better system to ensure all ected in a timely manner.				
	indicated room tray	Service policy, dated 4/14 vs would be removed from the in 2 hours after meal delivery.				
	On 4/14/16, at 10:3 director verified the	30 a.m. the maintenance following:				
	-Room 201: There along the edges of	was build-up of dark debris/di the floor.	rt			
		e was build-up of dark e edges of the floor.				
	badly gouged/scra	nside of the bathroom door wa bed, exposing bare wood. The ne was scratched and the was scraped.				
	curling up on the be black marred areas word "window" was wall paper. The ba right of the bathroo	athroom wall paper was ottom, in the seam and had s above the baseboard. The s written in black letters on the aseboard on the corner to the im door had a large piece eat register was scraped and				
	sink was cracked a and was not cleana bathroom door was bare wood. The he	orcelain finish in the bathroom and the ridges were easily felt able. The inside of the s deeply scratched, exposing eat register was scratched and tenance director stated the replaced.				
		nside of the room and the ere badly gouged, up high and				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00049	B. WING		04/	14/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
AUGUST	ANA MERCY CARE (ENTER	TH KENWOOL LAKE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21665	Continued From pa	age 12	21665			
	the door were badl edges. The bathro The heat register w maintenance direct needed to be repla -Room 317: The in badly scraped, exp -Room 407: The b next to toilet and w the toilet. There we The bathroom wall The maintenance of areas needed to be doors and registers	nside of the bathroom door was osing bare wood. athroom tile had a yellow stain as cracked around the base of ere dark stains in the cracks. next to toilet was soiled. director verified the soiled e cleaned and the scraped	5			
	concerns had not b rounds or by staff. The Monthly Qualit 3/14/16, lacked ide	room and verified the above been identified on the monthly y Assurance Rounds dated intification of the resident room				
	The undated Montl indicated the doors	on the environmental tour. hly Quality Assurance Checklis , floors and walls were to be recorded and corrected	t			
	The director of nur educate staff regar ensuring meal tray manner to avoid oc	THOD OF CORRECTION: sing (DON) or designee, could ding the importance of s are picked dup in a timely dors. The maintenance director ems to ensure resident areas				

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E SURVEY IPLETED	
			A. BUILDING	3:		
		00049	B. WING	04/	04/14/2016	
AME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
UGUST	ANA MERCY CARE	CENTER				
		MOOSE	LAKE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLE DATE	
21665	Continued From pa	age 13	21665			
	maintenance could	clean. The DON and director of I educate all appropriate staff ns to ensure ongoing	:			
	TIME PERIOD FO (21) days	R CORRECTION: Twenty-one				
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805		5/11/16	
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ect for their individuality by ersons providing service in a				
	by:	ent is not met as evidenced ion, interview and document		It is the policy of Augustana Mercy Health		
	dining experience i In addition, the faci	failed to ensure a dignified n 1 of 2 resident dining rooms. ility failed to ensure dignity was personal cares for 1 of 3 viewed for dignity.		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		
	p.m. until 6:26 p.m	servation on 4/11/16, from 5:40 ., residents were seated at 11 r dining room. In addition to a		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		
	room full of resider tables visiting. App	nts, 3 family members were at proximately half of the n served dinner, and the others		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		
	By 6:11 p.m., appro	oximately half of the residents		being reviewed by quality assurance		

PE4L11

If continuation sheet 14 of 23

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00049	B. WING		04/1	04/14/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE			
AUGUST	TANA MERCY CARE O	'ENTER	TH KENWOO LAKE, MN 5				
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE	
21805	Continued From pa	age 14	21805				
	 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 			committee to determine furth compliance needs . Correct	-		
	director of nursing expect staff not to u	4/14/16, at 1:43 p.m., the (DON) stated she would use the term "feeder" in nts. The DON stated they, be saying that."					
	use the commode. behind a curtain an visitors. In addition	chided for her frequent need to R12 used a commode just ad at times her roommate had , staff would open R12's vas on the commode so they ".					
	included frequency	dicated diagnoses which of micturition (frequent need muscle weakness and chronic	;				
	indicated R12 rece	der Report, dated 4/14/16, ived 40 milligrams (mg) of rice a day, at 8:00 a.m. and					

STATEMEN	Ita Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00049	B. WING		04/	14/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
AUGUST	ANA MERCY CARE C	ENTER	TH KENWOOD AKE, MN 557			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21805	Continued From pa	ge 15	21805			
	2/16/16, indicated F impairments in cog	imum Data Set (MDS), dated R12 had moderate nition, was always continent of and had no signs of delirium				
	R12 was to be toile to 11:30 a.m. (lunch	plan, dated 2/22/16, indicated ted every two hours and prior h). The goal indicated to have ler continence on the day shift.				
	stated staff don't all and dignity. R12 sta staff to answer her go, she had to go. I staff would come to and say they would	4/11/16, at 4:04 p.m., R12 ways treat her with respect ated she waited and waited for call light, and when she had to R12 continued to explain the the door, turn off the call light return in a few minutes, but R12 said she would have to again.				
	p.m., R12 and her r The roommate had came on and two s at 12:59 p.m. At 1: back on. At 1:17 p. room and shut the roommate and visit the day room. At 1:	n 4/13/16, beginning at 12:57 roommate were in their room. a male visitor. R12's call light taff responded with a Hoyer lift 09 p.m., R12's light came .m., two aides entered the door. At 1:21 p.m., R12's or exited the room and went to 24 p.m., R12 was sitting in her chair reading a book.				
	assistant (NA)-F sta the bedroom becau transfers and there move around the ro NA-F showed her g	4/13/16, at 1:32 p.m., nursing ated R12 used a commode in use she needed a Hoyer lift for was not enough room to commate into the bathroom. group sheet where she had e of the commode at 1:16 p.m.				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00049	B. WING		04/	04/14/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE			
		710 SOU	TH KENWOOL				
AUGUSI	ANA MERCY CARE (MOOSE	LAKE, MN 55	767			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FU		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	CTION SHOULD BE CON THE APPROPRIATE D		
21805	Continued From pa	age 16	21805				
	a.m., family member told that they can't bathroom so R12 u bedroom. FM-A state commode when R FM-A stated R12 h the staff don't ask t leave. FM-A state the window for "free commode. FM-A a air blew right on R1 commode. FM-A s use of the commode commode at care of	rview on 4/14/16, at 10:13 er (A) stated they have been get the Hoyer lift into the used a commode in the ated it's an issue of using the 12's roommate has company. as to sit behind the curtain and the roommate's company to d the staff will at times, open sh air" while R12 used the also stated when staff did that, 12 while she is sitting on the stated they have brought up the de and the cleanliness of the conferences. FM-A stated the commode was addressed, but I dignity issues.					
	urinate and she wo FM-A had observed and say, "You just	A12 has frequent urges to orried about "wetting herself". d the staff answer R12's light went". FM-A wondered if there number of times a resident can					
	stated that while th residents should ha stated she lost her she needed the lift,	4/14/16, at 11:04 a.m., R12 e curtain did get pulled, ave a little more privacy. R12 bathroom privileges, now that , but she "can't help it." R12 d her she's not the only one otty".					
	registered nurse (F staff would ask the while a resident is reiterated that staff to step out for a few	4/14/16, at 11:42 a.m., RN)-A stated she hoped that visitor to step out of a room using the commode. RN-A should ask family and visitors w minutes. RN-A stated it was residents. RN-A continued she					

Minnesc	ta Department of He	alth			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00049	B. WING		04/1	4/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AUGUST	ANA MERCY CARE C	ENTER	H KENWOO AKE, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21805	residents who have she educated staff "go less", you have she explained to sta not a behavior and can't go. Policies on privacy but not received. SUGGESTED MET interdisciplinary tea develop, review, an procedures to ensu maintained. The ID all staff on the polic	staff who were frustrated with urge issues. RN-A stated that you can t make someone to assist them. RN-A stated aff that an urge to urinate is they can't tell a resident they and dignity were requested THOD OF CORRECTION: The m (IDT)or designee could d/or revise policies and re all residents' dignity is T or designee could educate ies and procedures. The IDT develop monitoring systems to npliance.	21805			
21860	Residents of HC Fa Subd. 16. Confide and residents shall treatment of their p and may approve o individual outside th notified when perso any individual outsis someone to accom or information are to interview. Copies o information from the available in accord	.651 Subd. 16 Patients &	21860			5/11/16

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE S COMPL	
		00049	B. WING		04/14/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
AUGUST	ANA MERCY CARE O	'ENTER	TH KENWO AKE, MN 5	DD AVENUE 5767		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLET DATE
21860	Continued From pa	age 18	21860			
	Department of Hea	tions and inspections by the Ith, where required by third tracts, or where otherwise				
	by: Based on interview facility failed to ens (R134) received he that was understan that was most usef Findings include R134's face sheet i included cervical ra	ent is not met as evidenced and document review, the ure that 1 of 1 residents walth information in a manner dable and provided at a time ul to the resident. identified diagnoses that adiculopathy (damage to nerve n in the cervical vertebra),		It is the policy of Augustana Merce Care Center to fully inform reside advance about changes on their and treatment. An initial care con was held with resident R134 on 4, she reported that she was in agre with her plan of care and had no f concerns. On 4/15/16 facility socia met with resident R134 and provio with the medical records consent resident was provided with instruct	nts in care ference (15/16 ement urther al worker ded her form the	
	arthrodesis (fusion) anxiety and depres According to R134') of the cervical vertebra,		how to request copies of her med record. All facility staff were re- e on 4 /21/16 on procedure for addr concerns and medical records red the event a resident requests thei records. All staff that assist in car treatment plans will be educated of	ical ducated essing quests in r medical e and	
	member (FM)-B sta to the facility, they f incorrect. FM-B sa (RN)-G if they could and they were refus (RN-G was unavail	4/13/16, at 9:57 a.m., family ated when R134 was admitted felt the paperwork was id they asked registered nurse d see the interagency referral sed. According to FM-B able during the survey), RN-G interagency referral is in their ty's property.		need to fully inform residents in a about any changes on their care a treatment. At Care Conferences t resident/responsible party will be they have been informed in advar changes to their care and if the explanation was understandable. DON or designee will complete fix random audits per week for 4 wee then five per month for 3 months	dvance and he asked if nce about The re eks and	
	FM-B stated they h medications, amou epartment of Health	ad questions about R134's nt of assistance		compliance. All results will be revealed the facility quality assurance compliance.	riewed by	

PE4L11

If continuation sheet 19 of 23

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00049	B. WING		04/	14/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
AUGUST	ANA MERCY CARE O	YENTER	TH KENWOO _AKE, MN 5			
(X4) ID PREFIX TAG	ID SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21860	Continued From pa	age 19	21860		')	
	recommended, and did not feel that the questions in a time R134 could unders a good thing he wa	d if R134 could shower. FM-B facility answered their ly manner or in a manner that tand. FM-B also stated it was s there, as he provided all ing the first few days she was		determine further complia Corrected by 5/11/16	ance needs.	
di ta TI th ne ha co w fo In st a R ho	director of nursing talked to families of The DON stated re their medical record next day. The DON had a nurse sit with content. If a reside	4/14/16, at 1:53 p.m., the (DON) stated RN-G usually r residents upon admission. sidents can look at anything in d, usually the same day or the N clarified the facility usually n them to interpret the medical ent or their power of attorney acility has a standard consent				
	stated she was adr a rough start. R13 RN-G and gave he	4/14/16, at 1:59 p.m. R134 nitted on a Monday and it was 4 stated they were greeted by r the referral packet from the ted she had surgery on her a registered nurse.				
	or the next day, she appointments, restribasically what the " she asked to see th copy of it. R134 sai because they were told no. R134 said see her health infor time. According to person asked her "	n in the day she was admitted, e asked about her instructions, rictions, assistance needed, 'game plan was". R134 stated he interagency packet or get a tid it was very awkward in a public area and she was she knows it was her right to rmation, and said so at the R134, the unidentified staff what exactly are you asking				
anosota D		ed she replied, she just had a ne staff person then told her, o check on that."				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00049	B. WING		04/14/2016	
JAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S		14/2010	
		710 SOL	ITH KENWOOI			
406051	ANA MERCY CARE	MOOSE	LAKE, MN 55	767		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21860	Continued From pa	age 20	21860			
	that and go throug R134 said she had they were answere Questions such as used? Am I support walker? Am I support I transfer?. R134 do was held at lap lev was hard to see th couldn't truly review R134 also stated w medications she di asked the unidentified white pill" was. Th did not know and v R134 said it was "f someone who didr said they told her la stomach acid). To	id come in another day after h the chart with her, however, I questions and didn't feel that ed by RN-B, even at that time. : Why isn't a gait belt being sed to use a wheelchair or a bosed to have assistance wher continued to state the chart el, so with her neck brace on, i e chart and she felt that she w it. when she received her id not recognize them all and fied staff person what "the little e staff person replied that they vould have to check on it. reaky" to take pills from 't know what they were. R134 ater that it was just Pepcid (for further her frustration, staff when they were prescribed or	t			
	not to take pills wit	I a swallow study and was told hout them being crushed. es she was getting pill r times not.				
	interagency paper assistance in the fa transferring herself stay, but she never	as a discrepancy between the work and the implementation of acility. R134 stated she was f and had been throughout her r knew what the was from the hospital.				
	stated there were of	4/14/16, at 2:19 p.m., RN-B discrepancies in the paperwork referring hospital. RN-B stated				

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00049			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED
		B. WING		04/	04/14/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
AUGUSI	ANA MERCY CARE C		TH KENWOOD AKE, MN 557			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21860	she had to call the many times to get the many times to get the referring hospital Referral Form. RN-B stated she told FM-the referring hospital Referral Form. RN-B stated R134 with the of admission at R134 was an assist walker. In an interview on 4 stated she asked a shower nearby, as a bath or shower. R1 with no other inform someone told her b wondered why som don't know, but let r know; or, would you R134 said the staff, seem to know what everyone kept asking she had no idea. R planning a care corr involved in her care SUGGESTED MET The director of nurs dupheld. The DON regarding the regula personal medical reference.	referring hospital and clinic he correct orders. d bring R134's chart to her with her. However, RN-B B that they would have to call al for a copy of the Interagency was self-transferring at the and the paperwork indicated t of 1 with front wheeled //14/16, at 2:42 p.m., R134 staff person if there was a she hadn't been asked about a 34 reported she was told "no", hation. A day or so later ath days are Tuesdays. R134 eone couldn't have said, "I me find out and I'll let you a like to have a shower today?" including the therapists, didn't t the plan was for her, and ng her the "game plan", but 134 said even though they are aference, she did not feel		DEFICIENC	(Υ)	

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE 00049		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 04/14/2016		
		00049					
	PROVIDER OR SUPPLIER	I		DDRESS, CITY, STATE, ZIP CODE			
	ANA MERCY CARE (CENTER 710 SOL	JTH KENWOOI	D AVENUE			
		MOOSE ATEMENT OF DEFICIENCIES	LAKE, MN 55	PROVIDER'S PLAN OF			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21860	Continued From page 22		21860				
		R CORRECTION: Twenty-one					
	epartment of Health						