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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: PRQ3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00477

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245537**

2.STATE VENDOR OR MEDICAID NO.
(L2) **328542100**

3. NAME AND ADDRESS OF FACILITY
(L3) **MINNEWASKA COMMUNITY HEALTH SERVICES**
(L4) **605 MAIN STREET, PO BOX 40**
(L5) **STARBUCK, MN** (L6) **56381**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/15/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **65** (L18)

13.Total Certified Beds **65** (L17)

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

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	65			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Sherri Softing, HPR Dietary Specialist — 01/01/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 02/05/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/27/1989
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/08/2015
(L33)

Posted 02/18/2016 Co.

DETERMINATION APPROVAL

CCN: 24 5537

On January 15, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey completed on October 23, 2015, and deficiencies remaining uncorrected as of the PCR completed December 16, 2015. Mandatory Denial of payment for new Medicare and Medicaid admissions effective January 23, 2016. (42 CFR 488.417 (b)) has been rescinded. The facility's request for a continuing waiver involving health deficiency cited at F458 has been approved based on submitted documentation.Please refer to the CMS 2567B. Effective January 8, 2016 the facility is certified for 76 skilled nursing facility beds.

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245537
February 5, 2016

Mr. Christopher Knoll, Administrator
Minnewaska Community Health Services
605 Main Street, P.O. Box 40
Starbuck, Minnesota 56381

Dear Mr. Knoll:

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 January 8, 2016 the above facility is certified for or recommended for:

65 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 65 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 5, 2016

Mr. Christopher Knoll, Administrator
Minnewaska Community Health Services
605 Main Street, P.O. Box 40
Starbuck, Minnesota 56381

RE: Project Number S5537027

Dear Mr. Knoll:

On December 31, 2015, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective January 5, 2016. (42 CFR 488.422)

This was based on the deficiencies cited by this Department for a standard survey completed on October 23, 2015, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on December 16, 2015. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On January 15, 2016, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on December 16, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 8, 2016. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on December 16, 2015, as of January 8, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective January 8, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of December 31, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 23, 2016, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective January 23, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective January 23, 2016, is

to be rescinded.

In our letter of December 31, 2015, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 23, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on January 8, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition.

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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245537 Y1	A. Building B. Wing Y2	1/15/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEWASKA COMMUNITY HEALTH SERVICES	605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0325 Reg. # 483.25(i) LSC	Correction Completed 01/08/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☑	REVIEWED BY (INITIALS) GA/KJ	DATE 02/05/2016	SIGNATURE OF SURVEYOR 34982	DATE 01/15/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
10/23/2015	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PRQ3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00477

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245537**
2.STATE VENDOR OR MEDICAID NO.
(L2) **328542100**

3. NAME AND ADDRESS OF FACILITY
(L3) **MINNEWASKA COMMUNITY HEALTH SERVICES**
(L4) **605 MAIN STREET, PO BOX 40**
(L5) **STARBUCK, MN** (L6) **56381**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/16/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **65** (L18)
13.Total Certified Beds **65** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B, 8*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	65			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Timothy Rhonemus, HFE NEII 01/14/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/25/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/27/1989
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/08/2015
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5537

On Deember 16, 2015, a Post Certification Revisit was completed to verify the facility achieved and maintained compliance with federal certification requirements. Based on our revisit, we have determined the facility had not corrected all deficiencies issued pursuant to the October 23, 2015 standard survey. As a result of this visit, we imposed the Category 1 remedy of State monitoring and recommended to the CMS Region V office that they impose the following remedy:

- Mandatory Denial of Payment for new Mediare and Medicaid Admissions, effective January 23, 2016.

If denial of payment goes into effect, the facility would be subject to a two year loss of NATCEP, beginning January 23, 2016.

Post Certification Revisit to follow. Refer to the CMS 2567b and CMS 2567 along with the facilitys plan of correction.

Minnesota Department of Health

Electronically delivered
December 31, 2015

Mr. Christopher Knoll, Administrator
Minnewaska Community Health Services
605 Main Street, PO Box 40
Starbuck, Minnesota 56381

RE: Project Number S5537027

Dear Mr. Knoll:

On November 9, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 23, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On December 16, 2015, the Minnesota Department of Health and on December 13, 2015, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 23, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 4, 2015. Based on our visit, we have determined that your facility has not achieved substantial compliance with the health deficiencies issued pursuant to our standard survey, completed on October 23, 2015. The deficiency not corrected is as follows:

F0325 -- S/S: D -- 483.25(i) -- Maintain Nutrition Status Unless Unavoidable

The deficiency in your facility was found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective January 5, 2016. (42 CFR 488.422)

However, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 23, 2016.

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last

day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective January 23, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective January 23, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 23, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Minnewaska Community Health Services is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective January 23, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Jan.Suzuki@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov .

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:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: gail.anderson@state.mn.us

Phone: (218) 332-5140
Fax: (218) 332-5196

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

- Indicate how the facility plans to monitor its performance to make sure that solutions

are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

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

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction. If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

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 April 23, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Sincerely,

Mark Meath

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245537	A. BUILDING _____ B. WING _____	R 12/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEWASKA COMMUNITY HEALTH SERVICES	**605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on December 15-16, 2015. The certification tags that were corrected can be found on the CMS2567B. Also, there are tags that were not found corrected and/or new tags were issued at the time of onsite PCR which are located on the CMS2567. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 325} SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by:	{F 325}		1/8/16

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

Electronically Signed | 01/14/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245537	A. BUILDING _____ B. WING _____	R 12/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEWASKA COMMUNITY HEALTH SERVICES	**605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 325}	Continued From page 1 Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R41) with weight loss history and skin breakdown had interventions implemented to maintain acceptable nutritional parameters. Findings include: R 41's significant change Minimum Data Set (MDS) dated 10/13/15, indicated R41 had severe cognitive impairment, required limited assistance with eating, extensive assistance with ADLs, and had developed two stage II pressure ulcers, and one unstageable pressure ulcer. R41's Care Area Assessment (CAA) dated 10/13/15, indicated staff offer fluids with meals, snacks, skin is monitored, labs as ordered, and all changes were monitored. R41's care plan dated 10/21/15, indicated to offer diet as ordered, supplements as ordered, monitor problems with chewing and swallowing, offer snacks in between meals and as needed and feeding assessment quarterly and as needed. Review of R41's weights for the previous 6 months revealed the following: 7/14/15-183 pounds (lbs) 8/28/15-175 lbs 9/16/15-171 lbs 10/13/15-165 lbs 11/10/15-162 lbs 12/01/15-168 lbs Review of R41's Dietitian Recommendation dated 10/25/15, indicated, "Does sometimes have food left in mouth after meals when I stop by. Could be pocketing some food. Could have SLP	{F 325}	It is the policy of Minnewaska Lutheran Home that each resident shall receive proper nutrition...and is served the correct diet. The Director of Nursing or her designee is responsible to make sure that the resident's nutritional needs are being met. 1. The Care Plan and record of R41 were reviewed. Noted on 10/21/15 that a communication was sent to PCP to update on skin issue on (Lt.) foot bunion-Stage I. Interventions in place included APM mattress and floating heels. It was noted on 10/22/15 that an order was obtained for Ensure 8 oz. bid for weight loss and updated MD on bunion on (Rt.) foot-being painted with Betadine. Communication indicates that resident has been refusing to eat. On 10/29/15, seen by Greg Rapp, PAC as PCP was out of town. Orders received for OT to work on padding pressure areas on (Rt.) foot and minimize contact with (Lt.) foot and other bony prominences. On 10/25/15, received a dietary recommendation to try Arginine, 2 cal supplement versus Ensure, encourage high kcal/PRO snacks and supplements as tolerated and accepted D/T weight loss. May benefit from a Magic Cup daily as well as fortified cereal. Does sometimes have food left in mouth after meals. Could be pocketing some food. Could have SLP check him out to make sure all is ok? Does seem to need more assistance with meals at times D/T tired. On 11/5/15, communicated to PCP for an order for 2cal versus Ensure and requesting an order for Arginine. Order received to discontinue Ensure and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245537	A. BUILDING _____ B. WING _____	R 12/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEWASKA COMMUNITY HEALTH SERVICES	**605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 325}	Continued From page 2 [speech language pathologist] check him out to make sure all is ok?" Review of R41's Resident Progress Note dated 10/25/15, by registered dietician (RD) indicated R41 had multiple skin issues including pressure ulcer on hip, heel and side of foot and also weight loss noted. The note identified R41 was on a regular diet, had weight loss noted and appeared to hold some food in mouth after meals at times and will follow up for possible SLP screen. Review of R41's Resident Progress Note dated 11/18/15, by RD indicated history of skin issues and weight loss history. The note indicated R41 appeared nutritionally stable based on weight, fairly good intakes and skin healing process. The RD note did not address if a SLP evaluation had been completed or any follow up for the evaluation. Review of R41's Resident Progress Note dated 12/10/15, by RD indicated he continued to have skin issues, a bunion and blisters on his leg with a history of weight loss and at times does not eat well. The note indicated R41 appeared nutritionally fairly stable based on weight. The RD note did not address the request for SLP evaluation. During observation on 12/16/15, at 8:43 a.m., licensed practical nurse (LPN)-A was observed to change R41's dressing to his bunion on his right big toe. The area measured 1.0 centimeters (cm) by 1.5 cm. The area was irregular shaped, necrotic with no depth. During observation on 12/16/15 at 9:38 a.m. nursing assistant (NA)-A was observed to assist	{F 325}	Arginine. Resubmitted request for Arginine on 11/6/15 and received order. On 12/16/15, communicated Dietitian Recommendation R/T "SLP checking him out to make sure all is ok" and received response from PCP, that "patient is to uncooperative to benefit." No further recommendations have been made in regards to R41. 2. A review of all recommendations made by the Registered Dietician over the past two months has been completed. Communications have been sent to the PCP to update on recommendations and orders have been received as required for changes. All RN/Case Managers were educated on the policy/procedures to follow once a recommendations is received from the Registered Dietician. Following receipt of Dietary Recommendation, these recommendations will be reviewed at a weekly Medicare meeting. 3. Meeting with Registered Dietician, Dietary Manager, and DON was held to develop plan for recommendations and actions that will be taken to ensure recommendations are being followed up on. The Registered Dietician will make recommendations and send copies to the Dietary Manager, the Case Managers, and the DON. Following recommendations by the Registered Dietician, the Case Managers will review recommendations, update PCP on Dietary Recommendations, and implement all orders received. Within three working days of receiving the Dietician's Recommendations, the Case Managers	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245537	A. BUILDING _____ B. WING _____	R 12/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEWASKA COMMUNITY HEALTH SERVICES	**605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 325}	Continued From page 3 with feeding R41 his eggs, pancake, sausage and apple juice. R41 was observed to have no choking with eating the meal. During interview on 12/15/15, at 2:29 p.m. registered nurse (RN)-A stated the usual facility practice was to receive the dietician recommendations by e-mail from the RD and then she follows thru with the recommendations. RN-A confirmed she received the recommendations from the RD dated 10/25/15, and had missed the recommendation for a SLP evaluation for R41. RN-A confirmed R41 pocketed his food at times, and sometimes staff have to stop feeding him and remove food from his mouth. During interview on 12/16/15, at 9:31 a.m. NA-A stated she assisted R41 to eat often and sometimes when she assists him he does pocket his food. NA-A further stated he also coughed at times but was not sure if R41 was choking. During interview on 12/16/15, at 11:22 a.m. with the director of nursing (DON) verified R41 had not had an evaluation by SLP and stated he should have. She indicated the usual facility practice was for the RD to email any recommendations to the nurse manager (NM), and the NM was to follow up on the recommendations. RD returned a call placed during survey on 12/17/15, at 3:15 p.m. and stated she was concerned with R41 pocketing food and confirmed she had made a recommendation for R41 to be evaluated by the SLP. The RD stated her usual practice was to email her recommendations to the nurse managers and they are to follow thru with the recommendations.	{F 325}	will return the sheet to the Registered Dietician updating her on what actions have been taken R/T her recommendations and to ensure that she is aware that the recommendations have been addressed. The Registered Dietician will review the follow up on her next visit and sign off on the sheet. Intakes will be monitored on high risk residents and those who recommendations have been written for. The dietary department will complete intakes seven days for one week, two days during the second week, and one day during the third and fourth week. After four weeks the dietary supervisor will evaluate the effectiveness of the recommendation by reviewing the percent of intake of kcal and PRO. If supplements are ordered, percents of intake will be documented on the resident's MAR. Assistance and encouragement will be provided by nursing staff at mealtime to encourage increased intake. The Case Managers will evaluate the effectiveness for wound healing. At that time a decision will be made whether to continue with recommendations or contact PCP for a change in orders. Intakes will be monitored on high risk residents and those who recommendations have been written for. 4. Audits will be completed on all recommendations made by the dietician to ensure the proper steps are followed to ensure that the physician has been updated, orders have been processed and are being followed accordingly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245537	A. BUILDING _____ B. WING _____	R 12/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEWASKA COMMUNITY HEALTH SERVICES	605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381

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{F 325}	Continued From page 4 A facility Supervision of Resident Nutrition policy (last reviewed 12/3/15), indicated the facility would ensure residents received the proper nutrition and identified, "The director of nursing services and the director of food services (dietary manager) with input form the consultant dietitian if dietary manager is noting a deletion, must review the residents nutritional problems and coordinate all resolutions. Recommendations must be presented to the attending physician for his or her approval."	{F 325}	Audits will be completed whenever recommendations are received, for one week after order and been received and processed, and then weekly for one month until the recommendation has been determined effective. Audit will include monitoring of dietary intake collection, supplement administration, and follow-up to determine the recommendations are effective. Results of the audits will be brought to the Quality Assurance Committee to review and for further recommendations. Monthly at General Orientation, the Dietary Manager will address information R/T dietary to all new employees. During the Annual In-service, the registered Dietician will address issues R/T resident nutrition.	
{F 458} SS=E	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Submitted documentation supporting the facility ' s request for a continuing waiver involving deficiency cited at F0458 was previously forwarded to CMS. Approval of the waiver request was recommended.	{F 458}	Waivered tag: no plan of correction required.	

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245537	A. Building B. Wing	12/16/2015

Name of Facility	Street Address, City, State, Zip Code
MINNEWASKA COMMUNITY HEALTH SERVICES	605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **12/04/2015**	ID Prefix **F0310** Reg. # **483.25(a)(1)** LSC	Correction Completed **12/04/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **12/04/2015**
ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **12/04/2015**	ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **12/04/2015**	ID Prefix **F0490** Reg. # **483.75** LSC	Correction Completed **12/04/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By _____ **State Agency**	**Reviewed By** GA/mm	**Date:** 12/31/2015	**Signature of Surveyor:** 20794	**Date:** 12/16/2015
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 10/23/2015

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245537	01 - 01 - 1960 BUILDING AND ADDITIONS	12/13/2015

Name of Facility	Street Address, City, State, Zip Code
MINNEWASKA COMMUNITY HEALTH SERVICES	605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381

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(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0056	10/28/2015	ID Prefix Reg. # NFPA 101 LSC K0062	10/28/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** TL/mm	**Date:** 12/31/2015	**Signature of Surveyor:** 34764	**Date:** 12/13/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 10/20/2015		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245537	A. Building / B. Wing: 02 - 02 - 2004 ADDITIONS	12/13/2015

Name of Facility	Street Address, City, State, Zip Code
MINNEWASKA COMMUNITY HEALTH SERVICES	605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381

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(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0056	10/28/2015	ID Prefix Reg. # NFPA 101 LSC K0062	10/28/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	TL/mm	12/31/2015	34764	12/13/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 10/20/2015

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: PRQ3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00477

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245537**

2.STATE VENDOR OR MEDICAID NO.
(L2) **328542100**

3. NAME AND ADDRESS OF FACILITY
(L3) **MINNEWASKA COMMUNITY HEALTH SERVICES**
(L4) **605 MAIN STREET, PO BOX 40**
(L5) **STARBUCK, MN** (L6) **56381**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/23/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **65** (L18)

13.Total Certified Beds **65** (L17)

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B*8 (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	65			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Sherri Softing, HFE NEII 12/02/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 12/03/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/27/1989
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS

CCN: 24 5537

At the time of the October 23, 2015 standard survey the facility was not in substantial compliance with Federal participation requirements. The facility has been given an opportunity to correct before remedies would be imposed. The most serious deficiency iisolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections are required.

The facility's request for a continuing waiver involving health deficiency cited at F458 has been approved based on submitted documentation.

The Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
November 9, 2015

Mr. Christopher Knoll, Administrator
Minnewaska Community Health Services
605 Main Street, PO Box 40
Starbuck, MN 56381

RE: Project Number S5537027

Dear Mr. Knoll:

On October 23, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Minnesota Department of Health
1505 Pebble Lake Road #300
Fergus Falls, Minnesota 56537
gail.anderson@state.mn.us
Telephone: (218) 332-5140
Fax: (218) 332-5196

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 December 2, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 2, 2015 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 will be conducted to verify that

substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and 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 January 23, 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 April 23, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245537	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEWASKA COMMUNITY HEALTH SERVICES	605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide repositioning as directed by the care plan for 1 of 3 residents(R41) with current unstageable pressure ulcers, failed to implement ambulation services to prevent loss of function for 1 of 2 residents (R39) who required assistance with ambulation and failed to implement the care plan for 1 of 4 residents (R1) who required ROM services. Findings include: R 41's care plan dated 10/10/15, indicated R 41 was totally dependent on staff for locomotion, bed mobility, transfers and did not ambulate. R 41's care plan identified R 41 had current pressure ulcers to his right bunion, right heel and left hip, was at risk for developing further pressure ulcers and listed various interventions which included R 41 was able to tolerate a 2 hour repositioning program. R 41's care plan did not identify to float	F 282	It is the policy of Minnewaska Lutheran Home that a "Comprehensive Care Plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs shall be developed for each resident" and is being followed by qualified persons in accordance with each resident's written POC. The Director of Nursing or her designee is responsible to ensure that he resident is being provided services by qualified staff in accordance with the resident's written plan of care. 1. The Care Plan for R41 was reviewed, it was noted that on 10/29/15 he was seen by physician's assistant for declining condition and ulcers on feet & hip. Received order for OT to "work on padding pressure areas on (Rt.) foot, minimize contact with (Lt.) foot and bony prominences." Per OT evaluation on	12/4/15

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

Electronically Signed | 11/18/2015

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F 282	Continued From page 1 R 41's heels. On 10/21/15, R41 was continuously observed from 7:00 a.m. to 9:40 a.m. in bed asleep in a crooked body position. R41's trunk was twisted to his left side with his left hip and left buttocks were directly on the mattress, his legs were bent at the knee and facing left, his right foot was stacked on top of his left ankle. A 4 centimeter (cm) x 5 cm size scabbed, black area was visible to R41's right heel with the outermost part of the wound touching and pressing on the resident's left ankle. R41's right bunion wound was covered bit appeared to be pressing on his left outer foot. R41's left foot was directly on the mattress with the pillow displaced behind his calves and knees. The tip of the left heel was resting on the corner of the pillow. On 10/21/15, at 9:40 a.m. RN-C stated she was unaware R 41 had not been repositioned. She stated a staff member had "called in" this morning and they were struggling with staffing. RN-C observed and confirmed R 41 was lying on his left side with his left hip and buttocks directly on the bed, the bunion wound area stacked on top of his left foot, and the right heel wound resting on the inside of his left foot. RN-C confirmed R41's heels were not floated off the bed, and stated although staff try to float his heels, R 41 may have pulled the pillows out and up behind his knees. RN-C stated she would immediately assist R 41 to reposition. R39's current care plan updated 9/15/15, indicated she needed extensive assist of one staff for ambulation. The care plan also indicated R39 required extensive assistance for transfers. The	F 282	11/2/15, it was indicated that he would benefit from a "podus boot" which has been ordered. The "podus boot" arrived on 11/12/15 and have been placed on resident. Per OT, resident is to wear a "podus boot" bilaterally when up and pillow boots bilaterally when in bed. Bunion areas on bilateral feet are monitored BID until healed. Currently orders are to paint area on (Rt.) foot bunion with betadine BID. Bunion area on (Lt.) foot has a small scabbed area and is to be cleaned BID and monitor for continued healing. Continuous repositioning with use of APM mattress while in bed. Reposition/off load for two minutes q 2 hrs. while up in chair. Noted on 11/11/15, (Rt.) inner heel and (Lt.) hip ulcer have healed. The Care Plan for R39 was reviewed. On 10/23/15, order received for resident to be seen by PT/OT for evaluation and treatment. Per therapy notes, resident is non-compliant with therapy goals and has refused to ambulate with the therapy staff. On 11/09/15, resident was discharged from OT D/T refusal to participate in treatment sessions. Continues to be seen by PT but is noted to refuse to cooperate with treatment plan established with PT also. Once discharged from PT services, a rehab. program will be created by PT and added to the CNA's job duties. The Care Plan for R1 was reviewed. It was noted that resident was seen by PCP on 11/05/15 and per physician's note he indicated "good PROM & AROM in (Rt.) wrist, elbow, and reasonable ROM in (Rt.) shoulder without contractures."	

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F 282	Continued From page 2 care plan interventions directed facility staff to complete a restorative nursing program as indicated. On 10/19/15, at 5:46 p.m., R39 was seated in a wheelchair in her room. R39 stated staff were unable to assist her with walking because they didn't have enough staff. R39 stated the staff had stopped walking her at least a month ago and stated she wasn't sure whether she could walk any more. R39 further stated she hated to lose the ability to walk. On 10/20/15, at 11:32 a.m. R39 was observed seated in a wheelchair, propelling self to the dining area. At 2:30 p.m. R39 was observed seated in a wheelchair outside talking with other residents. R39 was not observed to ambulate throughout the day. On 10/21/15, at 3:15 p.m. the facility 's restorative nursing assistant (RA) stated she had been taken out of the restorative aid role to work on the floor to provide direct care. RA said this happened quite a bit and as a result she'd been unable to complete R39's daily ambulation program. RA stated she was aware R39 's ability to ambulate had declined and said she felt bad about not being able to assist R39 with her ambulation. RA also stated she'd noticed R39 would have difficulty standing when she hadn't been walked for a few days in a row. RA indicated the code of NS on the restorative therapy logs represented no shows for the days RA was pulled to the floor and therefore unable to complete R39's ambulation program. R39's restorative treatment log records were reviewed and revealed the following:	F 282	Reviewed ROM program; will be taught to CNA's and added to their job duties. 2. The facility reviewed all current residents with pressure ulcers or ROM services care plans to ensure the care plan was appropriate and interventions were implemented. To identify resident who may be at risk, on admission, quarterly and PRN, the case managers will complete the "Nursing Rehab Observation" assessing for functional limitations and ROM. They will also complete a Tissue Tolerance Test and Braden Scale Assessment monitoring for resident who are at risk for pressure ulcer development. If issues are noted in these areas, an intervention will be developed and placed in the resident care plan. Staff will be informed of these changes through daily report and through the Nursing Information sheet located at each nurse's station. Monitoring for compliance will be completed by the charge nurse and Case Manager. 3. All staff will be educated upon hire, annually, and PRN on the need to follow all resident's plan of care. They will also be educated on their responsibility in following the resident's plan of care. A review of ROM and ambulation techniques will be provided to Restorative Aide and she will in turn train all CNA's on performing ROM and ambulation correctly and safely. Once the training has been completed, ROM and ambulation will be added to the CNA job duties. Training will also be provided to staff so an understanding of the information provided on the T&R sheets will be clear for timely	

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F 282	Continued From page 3 In October 2015, there was no documentation for 15 out of 15 week days to indicate implementation of R39's ambulation program. This flow sheet indicated ambulation was done as needed (PRN.) In September 2015, R39's order for ambulation twice a day in room had been completed once a day for 8 of 30 days. R39 had received assistance with ambulating 100 feet on 9 out of 22 week days. The log indicated R39 had last received ambulation per her restorative plan on 9/10/15. The log was coded as NS for 10 of the 22 week days. In August 2015, R39's order for ambulation twice a day in room had been completed once a day for 8 out of 31 days. R39 had received assistance with ambulating 100 feet on 18 out of 21 week days. The log was coded as NS for 3 of the 21 week days. In July 2015, R39's order for ambulation twice a day in room had been completed once a day for 14 of 31 days. In addition, the logs indicated R39 received assistance with ambulating 100 feet on 19 of 23 weekdays days. The log was coded as NS on 4 days. In June 2015, R39 received assistance with ambulating 100 feet on 5 of 22 days. The log was coded as NS on 17 days. In May of 2015, R39 received assistance with ambulating 100 feet on 12 of 21 days. The log was coded as NS for 9 other days. On 10/23/15, at 8:41 a.m. RN-B confirmed R39	F 282	repositioning. 4. One observational audit will be completed daily, monitoring resident cares including repositioning, ulcer care, and ROM for one week, then bi-weekly for one week, then weekly for one month, and monthly X2 months by the DON or designee to ensure that the Care Plan is being followed by staff. Results of the audits will be brought to the Quality Assurance Committee to review and for recommendations.	

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F 282	Continued From page 4 had an active order for restorative nursing program to ambulate 3-5 times a week on week days, and confirmed R39's care plan directed facility staff to complete the restorative nursing program as indicated. RN-B stated she would expect R39's care plan to be followed. R1's current care plan updated 8/6/15, revealed R1 was totally dependent on facility staff for bed mobility, transfers and locomotion. The care plan revealed R1 was non-ambulatory and was assisted to transfer with a total body mechanical lift. The care plan directed facility staff to complete the restorative nursing program as indicated. R1's care plan did not identify R1's functional limitation of ROM of all extremities and did not address interventions for contractures. On 10/22/15, at 2:55 p.m. the facility's restorative nursing assistant (RA) was interviewed and stated R1 needed staff to provide ROM exercises 5 days a week to prevent stiffness. RA stated in the last few months R1 had become a lot tighter in the upper extremities on the right and left side. RA stated she was unable to spend the entire amount of time on exercises with R1 but stated she tried to squeeze 5 minutes of ROM in with R1 on the days when she (RA) was pulled to the floor so R1 wouldn't get tighter. The RA also stated when she was pulled to the floor to provide cares, she would still try to complete ROM for as many residents as she could between 2:30 p.m. and 4:30 p.m. She acknowledged she would not get the full repetitions in however, stated she documented on the rehab (rehabilitation) treatment logs so it may appear as though the 10 repetitions had been completed. RA also verified she had not reported R1's increased	F 282		

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F 282	Continued From page 5 tightness/stiffness to anyone. On 10/23/15, at 8:54 a.m. OT-A was observed to complete an upper extremity ROM assessment to determine R1's functional ROM. OT-A assisted R1 to move the left arm at the shoulder, elbow, wrist and fingers. OT-A stated R1's left hand and wrist had limitations fixed at 20-25 degrees of extension. OT-A also stated R1's left hand fingers were limited and all fingers were noted to have contractures. OT-A then assisted R1 to move the right arm at the shoulder, elbow, wrist and fingers. OT-A stated R1's right arm had a contracture at the elbow with extension. OT-A also stated R1's right arm had limited motion in the supine position. During assessment of the right wrist and shoulder R1 stated "ouch" and the assessment was stopped. OT-A confirmed R1's assessment revealed a decline in ROM for both upper extremities since her previous OT assessment more than a year ago. Review of R1's restorative nursing program logs for R1 to receive ROM to both upper and lower extremities for 10 repetitions, from May 2015, to October 2015, revealed the following: -May 2015, documentation indicated R1 did not receive ROM services for 5 out of 21 days. No further documentation was noted on the logs. -June 2015, documentation indicated R1 did not receive ROM services for 2 out of 22 days. No further documentation was noted on the logs. -July 2015, documentation indicated R1 did not receive ROM services for 2 out of 23 days. No further documentation was noted on the logs.	F 282		

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F 282	Continued From page 6 -August 2015, documentation indicated R1 had received ROM services 21 out of 21 days. No further documentation was noted on the logs. -September 2015, documentation indicated R1 had received ROM services for 22 out of 22 days. No further documentation was noted on the logs. -October 2015, documentation revealed R 1 did not receive ROM services 2 out of 16 days. The documentation also revealed R1's right side was more stiff both upper and lower extremity. On 10/23/15, at 4:19 p.m. the director of nursing (DON) stated she was the RN responsible to oversee the facilities restorative nursing program. The DON confirmed the RA had been pulled from restorative nursing frequently to provide residents cares because the facility was short staffed. She indicated restorative services and ROM services were not being provided to all residents in the facility consistently. The DON stated the administrator was aware restorative services and ROM services were not being provided to all residents in the facility consistently. The DON stated she was not aware R1 had a decline in ROM and was unaware R1 had contractures. A facility policy titled, Using the Care Plan, reviewed 7/14/09, revealed a statement the care plan would be used in developing the residents daily care routines. The policy directed facility staff to develop daily care assignments for NA's using the residents care plan. The policy also directed facility staff to report any changes in resident condition to the nurse and daily care and documentation must be consistent with the resident's care plan.	F 282		

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F 310	Continued From page 7	F 310		
F 310 SS=G	483.25(a)(1) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide ambulation services to prevent loss of function for 1 of 2 residents (R39) who required assistance with ambulation. R39 was not provided assistance with ambulation and was not re-assessed upon a decline in ambulation. R39's decline in the ability to ambulate resulted in actual harm. Findings include: On 10/19/15, at 5:46 p.m., R39 was seated in a wheelchair in her room. R39 stated staff were unable to assist her with walking because they didn't have enough staff. R39 stated the staff had stopped walking her at least a month ago and stated she wasn't sure whether she could walk any more. R39 further stated she hated to lose the ability to walk. On 10/20/15, at 11:32 a.m. R39 was observed seated in a wheelchair, propelling self to the dining area. At 2:30 p.m. R39 was observed	F 310	It is the policy of Minnewaska Lutheran Home that rehabilitative nursing care is performed daily for those who require such services. The Director of Nursing or her designee is responsible to ensure that rehabilitative services are provided to those residents who are in need of such services. 1. The Care Plan for R39 was reviewed. On 10/23/15, order received for resident to be seen by PT/OT for evaluation and treatment. Per therapy notes, resident is non-compliant with therapy goals and has refused to ambulate with the therapy staff. On 11/09/15, resident was discharged from OT D/T refusal to participate in treatment sessions. Continues to be seen by PT but is noted to refuse to cooperate with treatment plan established with PT also. Once discharged from PT services, a rehab. program will be created by PT and added to the CNA's job duties. 2. The facility reviewed all current	12/4/15

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MINNEWASKA COMMUNITY HEALTH SERVICES	605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381

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F 310	Continued From page 8 seated in a wheelchair outside talking with other residents. R39 was not observed to ambulate throughout the day. On 10/21/15, at 7:30 a.m. R39 was assisted to transfer out of bed by nursing assistants (NA)-I and NA-A with the use of a PAL lift (a mechanical lift device). R39 independently applied and attached the sling to the hooks of the lift. NA-I operated the lift while NA-A provided guidance and assisted her into a standing position. The NAs proceeded to wheel R39 in the PAL lift into the bathroom. NA-I lowered R39 onto the toilet with the PAL lift. NA-A handed clothing and hygiene supplies to R39 to independently complete her morning cares. On 10/21/15, at 9:00 a.m. R39 was observed seated in a wheelchair propelling herself back form the dining area. At 11:30 a.m. R39 was observed seated in a wheelchair outside visiting with other residents. R39 was not observed to ambulate throughout the day. On 10/22/15, at 1:00 p.m. R39 was observed seated in a wheelchair outside visiting. At 5:32 p.m. R39 was observed seated in a wheelchair sitting at a table in the dining room. At 6:00 p.m. R 39 was seated in a wheelchair and propelled herself back to her room. R39 was not observed to ambulate throughout the day. On 10/21/15, at 8:14 a.m. NA-I was interviewed and stated R39 used to be able to transfer with assistance of one staff with a gait belt and used to use the walker to walk into the bathroom. NA-I said R39 used to walk with staff assistance and the walker but was no longer able to. NA-I stated R39 had loved to walk and that she knew R39	F 310	residents with ROM services care plans to ensure the care plan was appropriate and interventions were implemented. To identify residents who may be at risk for loss of ADL's, on admission and quarterly the case managers will complete the "Nursing Rehab. Observation" assessing for functional limitations, ROM, and ambulation. If a decline in ability is noted, a referral will be made to therapy to assess/screen for need. PRN as a decline is noted, a referral is made to therapy to assess/screen for therapy or rehabilitative services. 3. A review of ROM and ambulation techniques will be provided to Restorative Aide and she will in turn train all CNA's on performing ROM and ambulation correctly and safely. Once the training has been completed, ROM and ambulation will be added to the CNA job duties. The assessment process will be reviewed. Staff will be educated on monitoring for changes in the resident's ability to complete ADL's and their responsibility to notify the Charge Nurse or Case Manager for further assessment. 4. One observational audit will be completed daily for one week, then bi-weekly for one week, then weekly for one month, and monthly X2 months by the DON or designee to ensure that the Care Plan is being followed by staff. Results of the audits will be brought to the Quality Assurance Committee to review and for recommendations.	

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missed walking. NA-I was unsure when R39 had become unable to walk and was not sure why.

On 10/21/15, at 3:15 p.m. the facility 's restorative nursing assistant (RA) stated she had been taken out of the restorative aid role to work on the floor to provide direct care. RA said this happened quite a bit and as a result she'd been unable to complete R39's daily ambulation program. RA stated she was aware R39 's ability to ambulate had declined and said she felt bad about not being able to assist R39 with her ambulation. RA also stated she'd noticed R39 would have difficulty standing when she hadn't been walked for a few days in a row. RA indicated the code of NS on the restorative therapy logs represented no shows for the days RA was pulled to the floor and therefore unable to complete R39's ambulation program.

On 10/22/15, at 10:10 a.m. during a follow up interview, R39 stated there had been changes in her ability to ambulate and that her legs had become weaker. R39 denied any illness or injury which might have affected her ability to ambulate. R39 stated at times her legs were weak due to low potassium, however she reported taking potassium supplements which had been effective. She stated that when she was unable to have assistance with walking her legs became weaker. R39 stated she felt bad for the staff because they were so busy and there weren't enough of them. She also stated at present, she was unsure if she would be able to walk if someone tried to help her. R39 also stated she would feel bad if another resident was unable to exercise because staff was exercising with her. She stated she used to be able to walk over 100 feet with her walker and staff assistance but that

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F 310	Continued From page 10 her walking exercises had ended about a month ago. R39's quarterly Minimum Data Set (MDS) dated 9/9/15, identified R39 was cognitively intact and identified diagnoses which included: pain in joint-lower leg, periodic paralysis from hypokalemia (low potassium) and anxiety. The MDS also identified R39 needed extensive assistance from staff for transfers and ambulation. A review of prior quarterly MDS assessments, conducted 3/11/15 and 6/11/15, indicated R39 had required extensive assistance for transfers, but had needed limited physical assistance from staff for ambulation. R39's activity of daily living (ADL)/functional status rehabilitation potential Care Area Assessment (CAA) dated 3/11/15, indicated R39 was cognitively intact, needed extensive assistance of one staff for transfers and ambulated in the room and hallway with extensive assistance of one staff and the use of a walker. The CAA further identified R39 had used a wheelchair with limited physical assistance from staff for locomotion on and off the unit. R39's current care plan updated 9/15/15, indicated she needed extensive assist of one staff for ambulation. The care plan also indicated R39 required extensive assistance for transfers. The care plan interventions directed facility staff to complete a restorative nursing program as indicated. R39's current physician orders signed 9/1/15, indicated R39 was to receive restorative nursing 3-5 times a week as scheduled by rehab (rehabilitative) staff, once a day on each	F 310		

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weekday. In addition, another order directed staff to ambulate R39 with a 4 wheeled walker (WW) with assistance of one, to/from the bathroom and in room transfers twice a day.

R39's restorative treatment log records were reviewed and revealed the following:

In October 2015, there was no documentation for 15 out of 15 week days to indicate implementation of R39's ambulation program. This flow sheet indicated ambulation was done as needed (PRN.)

In September 2015, R39's order for ambulation twice a day in room had been completed once a day for 8 of 30 days. R39 had received assistance with ambulating 100 feet on 9 out of 22 week days. The log indicated R39 had last received ambulation per her restorative plan on 9/10/15. The log was coded as NS for 10 of the 22 week days.

In August 2015, R39's order for ambulation twice a day in room had been completed once a day for 8 out of 31 days. R39 had received assistance with ambulating 100 feet on 18 out of 21 week days. The log was coded as NS for 3 of the 21 week days.

In July 2015, R39's order for ambulation twice a day in room had been completed once a day for 14 of 31 days. In addition, the logs indicated R39 received assistance with ambulating 100 feet on 19 of 23 weekdays days. The log was coded as NS on 4 days.

In June 2015, R39 received assistance with ambulating 100 feet on 5 of 22 days. The log was

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F 310	Continued From page 12 coded as NS on 17 days. In May of 2015, R39 received assistance with ambulating 100 feet on 12 of 21 days. The log was coded as NS for 9 other days. Nursing progress notes were reviewed from 8/1/15 to 10/23/15, and revealed the following: On 8/24/15, R39 had been educated on needing two staff assist with transfers due to R39 requesting one staff assist. On 9/6/15, R39 needed extensive assistance of two staff for transfers with a PAL lift. On 10/17/15, R39 was unable to ambulate daily related to increased weakness in legs, ambulation was changed to as tolerates. The note also revealed staff were to encourage R39 to ambulate when able. The progress notes lacked further documentation regarding R39's progress in the restorative nursing program for ambulation, and lacked any further description of R39's ambulation ability. Review of R39's care conference reports for June 2015 and September 2015, revealed the following: 6/18/15, R39 ambulated daily with assist of one staff with use of a walker. The notes revealed R39 was doing well with ambulation and had been taking potassium supplements daily for periodic paralysis which had been effective. 9/15/15, R39 ambulated daily with assist of one staff with use of a walker and needed assistance	F 310		

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F 310	Continued From page 13 with a mechanical PAL lift as needed for transfers. The note lacked assessment of of R39's restorative nursing program or any changes in the resident's ability to ambulate. On 10/22/15, at 3:13 p.m. registered nurse (RN)-B confirmed R39 had declined in ability to ambulate. RN-B stated she was unsure whether the decline was related to not getting restorative therapy consistently, or because her legs were weaker. RN-B confirmed R39 began needing assistance with a mechanical lift for transfers about a month ago. She verified R39 had been able to pivot transfer with one NA previously and that R39's decline in ambulation occurred at least a month ago. RN-B confirmed any decline in a resident's exercise could affect their overall ability. RN-B verified the RA was often pulled from restorative therapy to work as an aid on the floor. On 10/22/15, at 5:23 p.m. licensed practical nurse (LPN)-E stated she did not feel safe ambulating R39 at that time. LPN-E indicated R39 had not ambulated in multiple weeks and LPN-E refused to ambulate R39 at the present time. On 10/23/15, at 8:41 a.m. RN-B confirmed R39 had an active order for restorative nursing program to ambulate 3-5 times a week on week days, and confirmed R39's care plan directed facility staff to complete the restorative nursing program as indicated. RN-B stated she would expect R39's care plan to be followed. On 10/23/15, at 9:37 a.m. the director of nursing (DON) stated R39 had originally been referred for therapy on 3/25/15. That referral indicated staff were to provide restorative therapy for 2 weeks and then R39 was to have been re-evaluated by	F 310		

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F 310	Continued From page 14 therapy. The DON stated R39 had not been re-evaluated by therapy following the order on 3/25/15, and was unsure why. The DON confirmed R39 had not currently been receiving restorative therapy as ordered, 3-5 times a week (on week days). The DON also stated monthly treatment records would document ambulation provided by the NA's. When reviewed, the DON confirmed the lack of documentation on the treatment records and verified the NS codes on R39's restorative logs would indicate R39 had not been assisted with ambulation. During additional interview with the DON on 10/23/15, at 4:19 p.m. she stated she was the RN responsible for the restorative nursing program. The DON stated she was aware the RA was routinely pulled to the floor when they were short staffed and confirmed restorative services were not being provided consistently to the residents. The DON stated the administrator was also aware the RA was being pulled from restorative services and was aware restorative services were not being consistently provided to residents. A facility policy titled, Rehabilitative Nursing Care revised 2/18/13, revealed rehabilitative nursing care was provided to each resident that was admitted. The policy directed facility staff that rehabilitative nursing care was to be performed daily for those residents who required service. The program was to include assisting residents to carry out prescribed therapy exercises and assisting residents with their range of motion exercises.	F 310		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		12/4/15

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F 314	Continued From page 15 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement individualized interventions and/or provide appropriate wound treatment in order to prevent the development of, and/or enhance the healing of, pressure ulcers for 1 of 3 residents (R41) in the sample reviewed for pressure ulcers. The facility's failure to implement individualized interventions resulted in actual harm for R41. Findings include: R41 currently had unstageable pressure ulcers on a right bunion, right heel and left hip and was not provided timely repositioning and offloading as directed by the care plan. R41 had not been provided assistance to reposition or offload for a total of 5 hours. In addition, the facility failed to implement floating of R41's heels consistently. On 10/21/15, R41 was continuously observed from 7:00 a.m. to 9:40 a.m. in bed asleep in a crooked body position. R41's trunk was twisted to his left side with his left hip and left buttocks were directly on the mattress, his legs were bent at the knee and facing left, his right foot was stacked on	F 314	It is the policy of Minnewaska Lutheran Home that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they are unavoidable; and a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. 1. The Care Plan and records of R41 were reviewed. Noted on 11/11/15, (Rt.) inner heel and (Lt.) hip ulcer are healed. Resident was seen by physician's assistant on 10/29/15 with orders for OT to work on padding pressure areas on (Rt.) foot, minimizing contact with (Lt.) foot and bony prominences. Per OT, resident is to wear a "podus boot" bilaterally when up and pillow boots bilaterally when in bed. Bunion areas on bilateral feet are monitored BID until healed. Currently orders are to paint area on (Rt.) foot bunion area with betadine BID. Bunion area on (Lt.) foot has a small scabbed area and is to be cleaned BID and	

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F 314	Continued From page 16 top of his left ankle. A 4 centimeter (cm) x 5 cm size scabbed, black area was visible to R41's right heel with the outermost part of the wound touching and pressing on the resident's left ankle. R41's right bunion wound was covered bit appeared to be pressing on his left outer foot. R41's left foot was directly on the mattress with the pillow displaced behind his calves and knees. The tip of the left heel was resting on the corner of the pillow. On 10/21/15, at 9:40 a.m. RN-C stated she was unaware R 41 had not been repositioned. She stated a staff member had "called in" this morning and they were struggling with staffing. RN-C observed and confirmed R 41 was lying on his left side with his left hip and buttocks directly on the bed, the bunion wound area stacked on top of his left foot, and the right heel wound resting on the inside of his left foot. RN-C confirmed R41's heels were not floated off the bed, and stated although staff try to float his heels, R 41 may have pulled the pillows out and up behind his knees. RN-C stated she would immediately assist R 41 to reposition. On 10/21/15, at 9:53 a.m. R 41 was lying partially on his left side, with LPN-D, LPN-H and NA-G present in the room. R 41's right bunion area ulcer was observed to be approximately 1.5 cm x 1.5 cm, raised, necrotic and the surrounding skin was red in color. R 41's right medial heel wound was observed to be covered by a dark scab approximately 4 cm x 5 cm. R 41 moaned in pain when LPN-D touched or moved his right foot. R 41 moaned, flinched, grimaced, clenched his jaw, squeezed his eyes shut and complained of pain while LPN-D applied betadine to the right bunion wound. LPN-D stated R 41 did not receive any	F 314	monitored for continued healing. Continuous repositioning with use of APM mattress while in bed. Reposition/off load for one minute q 2 hrs. while up in chair. Care plan reviewed and updated as needed. 2. The facility reviewed all current residents with pressure ulcers care plans to ensure the care plan was appropriate and interventions were implemented. Upon admission, quarterly, and PRN Braden Skin Assessments and Tissue Tolerance testing is completed. Weekly with baths, a skin review and note are completed by the LPN. BID with AM/PM cares and PRN skin is monitored for changes. When changes are noted, the PCP is notified and an order is obtained for treatment. 3. All staff will be educated upon hire and annually on the need to follow all resident's plan of care. 4. One observational audit will be completed daily for one week, then bi-weekly for one week, then weekly for one month, and monthly X2 months by the DON or designee to ensure that the Care Plan is being followed by staff for the treatment and prevention of pressure ulcers. Results of the audits will be brought to the Quality Assurance Committee to review and for recommendations.	

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medication prior to wound care that she knew of. R 41 jumped, flinched, furrowed his brows, squeezed his eyes shut, clenched his teeth and moaned in pain when LPN-D applied a tegaderm dressing to his right heel. LPN-H removed R 41's brief, and the resident's skin and brief were observed to be visibly soiled with stool. The border of the left hip ulcer was observed. The border was an irregular circle shaped area, with a tail pointing towards his torso, shiny, granulation tissue was noted. During the observation, R41's heels were resting directly on the bed until NA-G applied a rigid, plastic lined boot to R 41's right foot. NA-G indicated she would be assisting R 41 into a wheelchair at that time.

At the time of this care, LPN-H stated R 41 received Tylenol for pain, but did not think R 41 was routinely pre-medicated before wound care or other cares. She stated overall, R 41 was pretty non-verbal, but did show facial expressions of pain, moaning and pulling away routinely. She stated R 41 always required 2 staff assistance with cares and they preferred to have 3 staff. NA-G stated R 41 had a history of stooling frequently throughout the day, sometimes 3 to 4 loose stools, that had attributed to R 41's skin condition. LPN-H indicated R 41's buttocks ulcer was healed right now, but felt R 41 remained at very high risk for skin ulcers.

On 10/21/15, at 1:59 p.m. LPN-D stated R 41 had really declined over the last few months. She stated she knew he was a challenge to get up in the morning, but wasn't sure how many staff if took to get him up. She stated he required staff assistance for repositioning. She stated normally she would check NA care sheets and monitor for repositioning and toileting but this morning she

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was busy and had not monitored. She stated the facility had a staff call in this morning and indicated she was unaware R 41 had not been checked on. LPN-D stated R 41 was to be repositioned every 2 hours, and that staff were expected to float his heels when in bed.

On 10/21/15 2:25 p.m. NA-G and registered nurse (RN)-C both indicated they were unaware of the last time R 41 had been repositioned prior to the 9:53 a.m. care. A review of R 41's turning and repositioning worksheet for that day indicated that prior to 9:53 a.m., R41 had been repositioned at 4:40 a.m. This was confirmed by NA-G and RN-C. During the interview, NA-G stated R 41 had been on an every 2 hour repositioning schedule since admission to the facility. She stated she always tried to float all residents' heels, but didn't think she had been specifically told to float R 41's heels consistently. NA-G said she was not able to reposition R 41 on time this morning because they were short staffed. She stated someone had called in sick this morning and the facility had pulled an NA from R 41's unit. Consequently they'd only had 2 NAs to take care of 21 residents who were all on an every 2 hour repositioning and/or toileting programs, many of whom had behaviors, and required feeding and other assistance. NA-G stated staffing had been a problem for a long time, but had gotten really bad since August.

On 10/21/15, at 2:27 p.m. registered nurse (RN-C) stated R 41 refused to lay on his right side and developed a pressure ulcer to his left hip because of this. She stated R 41 developed a pressure ulcer to his right bunion from swelling and pressure from his shoes. RN-C indicated R 41 used his right heel to self-propel himself in

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F 314	Continued From page 19 wheelchair and developed a blister to his right heel because of this. She stated she would expect staff to reposition R 41 every 2 hours as R 41 moved very little on his own. She stated there was "no excuse" for not repositioning him on time this morning. She confirmed R 41's care plan did not direct staff to float R 41's heels and stated she should have updated R 41's care plan and NA care sheets. She stated to float R 41's heels had been placed on the staff communication board, however, had not updated R 41's care plan. RN-C stated the usual facility protocol was to reposition all residents at least every 2 hours unless the resident's TTT indicated they required more frequent repositioning. On 10/21/15, at 3:06 p.m. LPN-H stated she had been working as a NA in the facility for awhile and worked both LPN and NA positions. She stated R 41 was supposed to be repositioned every 2 hours, and heels were supposed to be floated off the bed. She stated R 41 would get combative with cares and needed 3 people to complete his cares at times, but the facility only had 2 most of the time. She stated, "He is a prime example of our staffing shortage." She stated he was not repositioned on time because they were not fully staffed. She stated the facility had 2 NA' s for 21 people, all on 2 hour repositioning schedules, and required 2 staff assist with transfers and toileting. She said "if you do the math it doesn't add up." She stated it was really hard to make a resident wait because we don't have enough staff, but it's not safe to do cares with one staff like transfers with a lift, toileting, or repositioning either. R 41's admission Minimum Data Set (MDS) dated 3/12/15, indicated R 41 had	F 314		

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	245537	A. BUILDING _____ B. WING _____	10/23/2015

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diagnoses which included dementia, psychosis, muscle weakness and cerebral infarction (small stroke). MDS identified R 41 had severe cognitive impairment, significant weight loss and required extensive assist with all activities of daily living (ADLs). The MDS also identified R 41 was always incontinent of bowel, had intact skin, and was at risk for developing pressure ulcers.

R 41's admission pressure ulcer care area assessment (CAA) dated 3/18/15 identified R 41 had declined in ADL function, was incontinent of bowel and had advancing dementia. The CAA indicated R 41 never/rarely made decisions and was dependent on staff to anticipate all of his needs. The CAA further identified R 41's skin would be monitored daily during cares, assessed weekly during baths, and assessed using the Braden Scale and tissue tolerance tests (TTT) quarterly and as needed.

R 41's quarterly MDS dated 9/11/15 indicated R 41 had severe cognitive impairment, required extensive assistance with all ADL's, was always incontinent of bowel, and had no weight loss. The MDS further identified R 41 had a current stage II pressure ulcer, was at risk for developing further pressure ulcers, and had a pressure reducing device on his bed and wheelchair. The MDS did not identify R 41 was on a turning and repositioning program.

R 41's significant change MDS dated 10/13/15 identified R 41 had severe cognitive impairment, required extensive assistance with all ADLs. The MDS identified R 41 had 2 current stage II pressure ulcers and 1 unstageable pressure ulcer, and was at risk for developing further pressure ulcers The MDS did not identify R 41

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F 314	Continued From page 21 was on a turning and repositioning schedule R 41's significant change CAA dated 10/19/15 indicated R 41 had an increase in dementia, required extensive assistance of 2 staff and a mechanical lift for all transfers, and had inadequate nutrition and signs of dehydration. The CAA further indicated R 41 required extensive assistance to move in bed, had current stage II and unstageable pressure ulcers on hip and feet, had pressure reducing mattress, gel cushion in wheelchair, and was to be repositioned per facility protocol. R 41's care plan dated 10/10/15, indicated R 41 was totally dependent on staff for locomotion, bed mobility, transfers and did not ambulate. R 41's care plan identified R 41 had current pressure ulcers to his right bunion, right heel and left hip, was at risk for developing further pressure ulcers and listed various interventions which included R 41 was able to tolerate a 2 hour repositioning program. R 41's care plan did not identify to float R 41's heels. Review of R 41's weekly skin integrity events, identified by the facility as comprehensive wound assessments revealed the following: -8/17/15 bruise to left gluteal fold and upper thigh, from catheter, catheter education was to be done for staff, inner right bunion area measured 0.7cm x 0.5cm, 1.5 cm in diameter, monitor. --8/30/15 left hip stage II pressure ulcer measured 6cm x 4cm with a 3cm x 1cm scab and right bunion area measured 1cm x 0.5cm. -9/16/15 right heel 4.5cmx3.5cm area with black	F 314		

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circle surrounding it, mild to moderate pain, elevate, float heels, pain management, left hip 2cm x 1.5cm with a 3cm x 2.5cm bruise surrounding it, mild to moderate pain, left buttocks, 1.5cm x 1.5cm, stage I with white and pink tissue surrounding area, not open, hard lump underneath, mild to moderate pain.

-9/18/15 right bunion 1 cm circular, unstageable, necrotic, 100% hard, paint with betadine, elevate. Right heel, 2cm x 2cm blister, unable to assess wound bed, mild to moderate pain, weight loss, decreased food intake.

A progress note dated 10/19/15 identified an error in documentation of location of R 41's pressure ulcers. The note identified the documentation dated 9/23/15. 9/30/15, 10/7/15, 10/14/15 as right hip pressure ulcer, should have been left hip pressure ulcer and 10/14/15 documentation of left heel, should of been right heel pressure ulcer.

-9/23/15 right hip stage II 4.5cm x 2.5cm with 1.5cm x 2.0cm red center, R 41 had no pain, decreased food intake, and weight loss. Right heel stage II, 5cm x 4cm, no pain. Right bunion unstageable, 1cm x 1cm, necrotic, moderate pain at site.

-9/30/15 right heel stage II, 4cm x 2cm, moderate pain, continued with decreased food intake and weight loss, right hip 2cm x 1cm with a 4.5cm x 2cm bruise around it, no pain. Right bunion 2cm x 1cm, unstageable, necrotic, moderate pain.

-10/7/15 right heel stage II, necrotic, no pain, R 41 had decreased food intake and weight loss. Right bunion unstageable, necrotic, no pain, Left hip stage II, 2.5cm x 3cm with a 2.5cm tail, no

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F 314	Continued From page 23 pain. -10/14/15 right hip stage II, necrotic, 1.5cm x 2cm with a cm bruise-tail, no pain, decreased food intake and weight loss. Right heel, stage II, necrotic, mild pain, right bunion, unstageable, necrotic, mild pain at site. Review of R 41's Braden Scale for Prediction of Pressure Sore Risk forms dated 3/6/15, 6/11/15, and 9/16/15 revealed R 41 had been identified at risk for developing pressure ulcers due to limited mobility, occasionally moist skin and had a potential for friction and shear on all completed forms. Review of R 41's tissue tolerance tests (TTT) forms dated 6/13/15, 9/7/15, 9/10/15, 9/16/15 and 10/10/15 revealed for both lying and sitting positions R 41 had been identified to tolerate a 2 hour repositioning program. On 10/23/15, at 4:08 p.m. DON stated she would expect a comprehensive assessment, documented in the facility computerized system as a skin integrity event, each week for each pressure ulcer. She confirmed R 41's care plan included every 2 hour repositioning and indicated she would expect R 41's heels to be floated consistently. The facility's Skin Care Policy dated 8/24/09, indicated "a resident who enters the facility without pressure sores does not develop pressure sores unless they are unavoidable; and a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing."	F 314		

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F 318 SS=G	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently provide range of motion (ROM) services for 1 of 4 residents (R1) reviewed for ROM. Due to the deficient practice R1 sustained actual harm, a reduction in ROM and development of worsening contractures. Findings include: On 10/22/15, at 2:55 p.m. the facility's restorative nursing assistant (RA) was interviewed and stated R1 needed staff to provide ROM exercises 5 days a week to prevent stiffness. RA stated in the last few months R1 had become a lot tighter in the upper extremities on the right and left side. RA stated she was unable to spend the entire amount of time on exercises with R1 but stated she tried to squeeze 5 minutes of ROM in with R1 on the days when she (RA) was pulled to the floor so R1 wouldn't get tighter. The RA also stated when she was pulled to the floor to provide cares, she would still try to complete ROM for as many residents as she could between 2:30 p.m. and 4:30 p.m. She acknowledged she would not get the full repetitions in however, stated she	F 318	It is the policy of Minnewaska Lutheran Home that rehabilitative nursing care is provided daily for those residents who require such services. The Director of Nursing or her designee is responsible to ensure that the resident is being provided services to increase and /or prevent further decrease in ROM. 1. The Care Plan and record of R1 were reviewed. Per past medical history, resident is diagnosed with severe spasticity after her cerebral injury, requiring Baclofen pump and BP shunt. It was noted on 11/5/15 that resident was seen by her PCP, Dr. Bosl, and was noted that resident had good PROM and AROM in (Rt.) wrist, elbow, and reasonable ROM in (Rt.) shoulder without contractures. Resident has an order for a (Lt.) hand splint to be placed on at bedtime and removed when up in the morning. Upon removal of the hand splint, a finger/digit separator is placed on the (Lt.) hand. Skin is checked for signs of skin breakdown. She will continue to receive upper and L/E PROM provided by the	12/4/15

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F 318	Continued From page 25 documented on the rehab (rehabilitation) treatment logs so it may appear as though the 10 repetitions had been completed. RA also verified she had not reported R1's increased tightness/stiffness to anyone. On 10/22/15, at 5:04 p.m. nursing assistant (NA)-J stated she was unaware whether R1 was receiving ROM services but was aware R1 was stiffer in her arms at times. NA-J stated it was not the facility's usual practice for NAs to complete ROM services. NA-J stated restorative nursing usually completed ROM for all residents in the facility. At 5:06 p.m. NA-J was observed to provide passive range of motion (PROM) exercise to R1's right and left arms. R1's right arm was able to be moved just at shoulder height before R1 cried out in pain and NA-J stopped the movement. R1's left arm was able to be moved to less than shoulder height and NA-J stated R1 was too tight to continue the exercises on. NA-J confirmed R1 was tighter than normal. On 10/22/15, at 5:10 p.m. licensed practical nurse (LPN)-E stated R1 was stiffer in both arms in the last few months. LPN-E stated she had noticed R1 was stiffer when the restorative aid was unable to complete R1's ROM exercises due to being pulled to the floor to provide cares. LPN-E stated the RA would still try to do as many residents ROM as possible after working the floor, however the time was limited then and the RA was not able to complete the full exercise regimen. On 10/23/15, at 8:27 a.m. occupational therapist (OT)-A stated R1 had not had a recent occupational therapy evaluation for ROM exercises. OT-A stated she'd understood R1	F 318	CNA's daily per Care Plan. 2. The facility reviewed all current residents with ROM services care plans to ensure the care plan was appropriate and interventions were implemented. To identify other residents who may be at risk, upon admission, quarterly and PRN, a Nursing Rehab. Observation will be completed reviewing functional limitations in upper and L/E's. If noted, a request will be submitted to therapy for an assessment. Other interventions will be initiated as appropriate to the limitations. 3. All staff will be educated of the need to report any changes in resident's condition to the charge nurse and Case manager immediately. A review of technique of ROM will be provided to all nursing staff and will become the responsibility of the nursing assistants to perform as care planned. 4. One observational audit of ROM being performed will be completed daily monitoring for completion of ROM per resident's POC for one week, then bi-weekly for one week, then weekly for one month, and monthly X2 months by the DON or designee to ensure that the Care Plan is being followed by staff for the treatment and prevention of pressure ulcers. Results of the audits will be brought to the Quality Assurance Committee to review and for recommendations.	

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recieved execrcises by restorative nursing, and stated she was unaware R1 had experienced a decline in ROM.

On 10/23/15, at 8:54 a.m. OT-A was observed to complete an upper extremity ROM assessment to determine R1's functional ROM. OT-A assisted R1 to move the left arm at the shoulder, elbow, wrist and fingers. OT-A stated R1's left hand and wrist had limitations fixed at 20-25 degrees of extension. OT-A also stated R1's left hand fingers were limited and all fingers were noted to have contractures. OT-A then assisted R1 to move the right arm at the shoulder, elbow, wrist and fingers. OT-A stated R1's right arm had a contracture at the elbow with extension. OT-A also stated R1's right arm had limited motion in the supine position. During assessment of the right wrist and shoulder R1 stated "ouch" and the assessment was stopped. OT-A confirmed R1's assessment revealed a decline in ROM for both upper extremities since her previous OT assessment more than a year ago.

On 10/23/15, at 1:44 p.m. during a follow up interview, RA stated her usual practice when a residents ROM changed, was to notify the nurse and therapy so they could complete an evaluation of the resident. RA confirmed R1 was stiffer in both upper extremities, especially when R1's ROM exercises were not done for 2 or more days. RA confirmed R1 had contractures and was aware she had gotten stiffer in the recent past.

R1's quarterly Minimum Data Set (MDS) dated 7/29/15, identified R1 had moderately impaired cognition and had diagnoses which included quadriplegia (loss of voluntary movement to extremities), cerebral vascular accident (CVA)

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with aneurysm and cerebral bleed (blood clot which had ruptured in the brain.) The MDS also identified R1 needed total assistance of two staff with activities of daily living (ADL's) and had limited functional range of motion (ROM) to both upper and both lower extremities.

R1's annual MDS dated 1/30/15, identified R1 needed total assistance with ADL's and had limited funtional ROM to both upper and lower extremities.

R1's Communication Care Area Assessment (CAA) dated 1/30/15, identified R1 was able to be understood, had clear speech and did well when asked yes and no questions.

R1's ADL's functional status/rehabilitation potential CAA dated 1/30/15, identified R1 was totally dependent on staff for all ADL's.

R1's CAA did not address R1's functional limitation of ROM of all extremities and did not identify contractures. In addition, the CAA indicated a referral to other disciplines was not warranted and to continue the plan of care.

R1's Nursing Rehab Observation dated 7/30/15, identified R1 had functional limitations in ROM to both the upper and lower extremities. The form did not address any changes of R1's ROM.

R1's Nursing Rehab Observation dated 4/27/15, identified R1 had functional limitations in ROM to both the upper and lower extremities. The form did not address any changes of R1's ROM.

R1's current care plan updated 8/6/15, revealed R1 was totally dependent on facility staff for bed

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F 318	Continued From page 28 mobility, transfers and locomotion. The care plan revealed R1 was non-ambulatory and was assisted to transfer with a total body mechanical lift. The care plan directed facility staff to complete the restorative nursing program as indicated. R1's care plan did not identify R1's functional limitation of ROM of all extremities and did not address interventions for contractures. Review of R1's current physician orders dated 9/15/15, revealed an order for a restorative nursing program dated 5/6/09, for 3-5 times a week as scheduled by rehab staff for a diagnosis of quadriplegia, once a day Mon, Tue, Wed, Thu, Fri. Review of R1's monthly treatment records, order for nursing restorative program, once a day Mon, Tue, Wed, Thu, Fri 3-5 times per week as scheduled by rehab staff from to 9/30/15 revealed the following: 10/1/15 to 10/22/15, the treatment record documentation revealed no documentation of R1's ROM services had been provided 16 out of the 16 days. -9/1/15 to 9/30/15, the treatment record revealed no documentation of R1's ROM services had been provided 16 out of the 21 days. -8/1/15 to 8/31/15, the treatment record revealed no documentation of R1's ROM services had been provided 21 out of the 21 days. -7/1/15 to 7/31/15, the treatment record revealed no documentation of R1's ROM services had been provided 2 out of the 23 days.	F 318		

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Review of R1's restorative nursing program logs for R1 to receive ROM to both upper and lower extremities for 10 repetitions, from May 2015, to October 2015, revealed the following:

-May 2015, documentation indicated R1 did not receive ROM services for 5 out of 21 days. No further documentation was noted on the logs.

-June 2015, documentation indicated R1 did not receive ROM services for 2 out of 22 days. No further documentation was noted on the logs.

-July 2015, documentation indicated R1 did not receive ROM services for 2 out of 23 days. No further documentation was noted on the logs.

-August 2015, documentation indicated R1 had recieved ROM services 21 out of 21 days. No further documentation was noted on the logs.

-September 2015, documentation indicated R1 had received ROM services for 22 out of 22 days. No further documentation was noted on the logs.

-October 2015, documentation revealed R 1 did not receive ROM services 2 out of 16 days. The documenation also revealed R1's right side was more stiff both upper and lower extremity.

Review of R1's nursing to rehabilitation notification change in functional status/order forms revealed the following;

-9/8/15, screening requested to check left hand brace, and fingertips. OT educated staff on correct application of day finger/digit seperator

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F 318	Continued From page 30 and indicated no further OT needed at this time. -8/7/15, screening requested for blister/ulcer to R1's left heel. OT determined sheep skin in foot pedals and dycem under the sheep skin appropriate to keep in place. -6/3/15, screening requested to replace R1's left hand brace, OT completed screening, and identified R1's case manager had reported the brace missing for a while. OT located the brace and presented it to the case manager, no further services provided. The forms lacked information of R1's increased stiffness to right and left upper extremities. In addition, the forms did not indicate a change in R1's restorative nursing program. On 10/23/15, at 2:02 p.m. registered nurse (RN)-B denied R1 had contractures in any of her extremities and indicated the facility only had one resident with a contracture at present. RN-B further stated if a resident had a decline or a loss in ROM, the physician would be notified to see if a referral to therapy would be appropriate. RN-B was unaware R1 had any loss or decline in ROM. RN-B stated she was aware R1 was getting restorative nursing services for ROM exercises to all extremities, but was unaware if R1 had received the full exercise program. RN-B stated she would expect R1 to receive full ROM exercises to all extremities according the restorative nursing program. On 10/23/15, at 2:09 p.m. NA- G stated she was aware R1 was a lot stiffer in the upper arms when assisting R1 with dressing. NA-G stated R1 wore a brace to the left arm at night and brace on both	F 318		

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F 318	Continued From page 31	F 318		

feet during the day. NA-G stated restorative nursing was responsible for completing R1's ROM exercises. NA-G stated if the restorative aid was working on the floor then residents would not get their exercises.

On 10/23/15, at 3:30 p.m. NA-A stated R1's arms were stiffer when dressing and undressing in the last few months. She stated R1 recieved restorative nursing exercises when the RA was available to complete the restorative nursing program. . NA-A stated she was aware R1 had become stiffer in the last few months NA-A stated R1 received restorative nursing exercises when the restorative aid was not working on the floor.

On 10/23/15, at 4:19 p.m. the director of nursing (DON) stated she was the RN responsible to oversee the facilities restorative nursing program. The DON confirmed the RA had been pulled from restorative nursing frequently to provide residents cares because the facility was short staffed. She indicated restorative services and ROM services were not being provided to all residents in the facility consistently. The DON stated the administrator was aware restorative services and ROM services were not being provided to all residents in the facility consistently. The DON stated she was not aware R1 had a decline in ROM and was unaware R1 had contractures.

A facility policy titled, Rehabilitative Nursing Care revised 2/18/13, revealed rehabilitative nursing care was provided to each resident who was admitted. The policy directed facility staff to provide rehabilitative nursing care to be performed daily for those residents who required those services. The policy indicated the program was to include assisting residents to carry out

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F 318	Continued From page 32 prescribed therapy exercises and assisting residents with their range of motion exercises. An undated facility policy titled Range of Motion Exercises, identified steps to complete ROM exercises for residents. The policy directed facility staff to report any changes in ROM to the charge nurse and indicated the ROM exercises should be documented in the resident's medical record with the following information; date and time performed, name and title of person who performed the service, what type of ROM, whether the exercises were active or passive, how long the exercise was conducted, if and how long the resident participated in the procedure, any changes in the resident's ability to participate, any problems or complaints made by the resident and if the resident refused and why.	F 318		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident	F 325	It is the policy of Minnewaska Lutheran Home that each resident shall receive	12/4/15

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F 325	Continued From page 33 (R41) with weight loss and skin breakdown had interventions implemented to maintain acceptable nutritional parameters. Findings include: R41's admission Minimum Data Set (MDS) dated 3/12/15, indicated R41 had diagnoses which included dementia with behavioral disturbance, psychosis, anemia, and history of urinary tract infection. The MDS further indicated R41 had severe cognitive impairment, significant weight loss, required limited assistance with eating, required extensive assistance with activities of daily (ADL), and had intact skin. The cooresponding care area assessment (CAA) dated 3/18/15, indiated R41 never/rarely made decisions and was dependent on staff to anticipate his needs. The CAA also indicated R41 was to maintain his current nutritional level with stable weight. The quarterly MDS dated 9/11/15, indicated R41 had severe cognitive impairment, required limited assistance with eating, required extensive assistance with ADL's, had no weight loss, had a current stage II pressure ulcer, and received pressure ulcer care. A significant change MDS dated 10/13/15, indicated R41 had severe cognitive impairment, required limited assistance with eating, extensive assistance with ADL's, and had developed two stage II pressure ulcers, and 1 unstageable pressure ulcer. The corresponding CAA dated 10/19/15, indicated R41 had inadequate nutrition, and signs of dehydration related to increasing dementia. The CAA indicated staff were to offer fluids with meals, snacks, medication passes and	F 325	proper nutrition...and is served the correct diet. The Director of Nursing or her designee is responsible to make sure the resident's nutritional needs are being met. 1. The Care Plan and record of R41 were reviewed. On 10/15/15, dietary director documented that resident consumes on the average of between 75-100% from all food groups. On 10/22/15, resident received an order for Ensure 8 oz. BID. Per registered dietician, on 10/25/15, residents BMI was 25.8 (representing a healthy weight status) even with a weight loss noted over 3 months of 6.25%. Per registered dietician's recommendations Ensure was discontinued and started on 2 cal 4 oz. BID on 11/05/15. Requested an order for Arginine at that time but did not receive from MD. On 11/6/15 did received an order for Arginine. As of 11/11/15, the areas on (Rt.) inner heel and (Lt.) hip have healed. 2. The facility reviewed all current residents with pressure ulcers care plans to ensure the care plan was appropriate and interventions were implemented. To identify resident who may be at risk for having nutritional issues, upon admission a weight is obtained and weekly with each bath. The dietary manager determines the resident's BMI and a average acceptable weight is determined from the first four bath weights. Intakes are obtained at each meal for seven days upon admission, quarterly and PRN. The registered dietician reviews resident's charts and makes recommendations which are documented in the clinical notes and sent to the Case Managers to	

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F 325	Continued From page 34 care. The CAA also identified R41's stage II and unstageable pressure ulcers on his hip and feet. R41's care plan dated 10/10/15, included nutritional interventions for R41's pressure ulcers to the right bunion, right heel and left hip. The nutritional goal included: to maintain current level of nutrition and stable weight. The interventions included: assistance of one to eat, supplements as ordered, offer snacks between meals and as needed, record intake quarterly and as needed, and weigh weekly. On 10/21/15, at 9:53 a.m. R41's pressure ulcers were observed. The pressure ulcer over the bunion was observed to measure approximately 1.5 centimeters (cm) x 1.5 cm. The area was red, raised and necrotic. R41's right medial heel ulcer had a dark scab approximately 4 cm x 5 cm. The pressure ulcer on the hip was observed to be an irregular circle shaped area, with a tail like area pointing toward the resident's torso. The area appeared shiny with granulation tissue noted. During observation of the breakfast meal on 10/21/15, at 10:54 a.m. R41 was assisted to eat 1/2 a piece of french toast, 1/2 a sausage patty, 1/2 portion of a scrambled egg, and a glass of cranberry juice. Review of R41's current physician's order report from 9/22-10/22/15, revealed R41 had physician orders for ferrous sulfate 325 milligrams (mg) once a day on since 4/2/15, Lasix (diuretic medication) 40 mg daily once a day since 9/3/15, Paxil 10 mg po daily (reduced from 20 mg 10/15/15), Xanax 0.125 mg daily (reduced from 0.25 mg 10/15/15). The orders also included	F 325	obtain an order and implement recommendations. If supplements are ordered, percent of intake are documented on the resident's MAR. Assistance and encouragement are provided at mealtime to encourage increased intake. 3. All nursing staff will be educated on the procedures to follow when noted decline in resident's nutritional status, such as body weight and clinical condition. 4. One observational audit will be completed daily monitoring for compliance with monitoring and obtaining interventions for residents who demonstrate nutritional issues for one week, then bi-weekly for one week, then weekly for one month, and monthly X2 months by the DON or designee to ensure that the Care Plan is being followed by staff for the treatment and prevention of pressure ulcers. Results of the audits will be brought to the Quality Assurance Committee to review and for recommendations.	

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F 325	Continued From page 35 prescripton for a general diet and did not include an order for any nutritional supplements. R41's weights were reviewed for the previous 6 months: 4/14/15-183 pounds (lbs) 7/14/15-176 lbs 8/28/15-175 lbs 9/16/15-171 lbs 10/13/15-165 lbs The facility's Resident Temporary Care Plan worksheets were reviewed. The worksheets indicated R41 had an emergency room visit and antibiotic treatment initiated on 8/15/15. In addition, the worksheets indicated R41 had previously utilized Risperdal to manage behaviors, which had been discontinued and Xanax had been initiated 9/15/15. Resident Progress Notes indicated R41 experiened a 10# weight loss from 8/28/15 to 10/13/15. The Resident Progress Notes also indicated R41 developed new pressure ulcers which had deteriorated. Nutritional progress notes revealed the following: 6/09/15, R41 had open areas on his scrotum, back of thighs, and buttocks from friction. R41 was on a regular diet and was independent with eating, had a significant weight loss of 5% over 1 month, declined meal intakes, was offered fluids with meals, medications, snacks and water pass to assist with hydration. R41'a body mass index (BMI) 27.2, represented healthy to overweight health status. May benefit from high protein foods/snacks to assist with healing process and weight stability due to weight loss and skin	F 325		

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issues. Will continue to monitor and assess as needed. Nutritional assessment did not identify R41's nutrition needs or what his current intakes were, or if current nutrition interventions were effective.
8/28/15, R41 returned from emergency room with diagnoses of pneumonia and urinary tract infection. R41 was on a regular diet and was independent with eating. R41's weight was noted to be fairly stable since admission, with BMI 27.2. Some declined meal intakes noted and R41 was to be offered fluids with meals, medications, snacks and water pass to assist with hydration. May benefit from high protein foods/snacks to assist with weight stability and skin integrity. Will continue to monitor and assess as needed. Nutritional assessment did not identify R41's nutrition needs or what his current intakes were, or if current nutrition interventions were effective.

9/14/15, R41 was on a regular diet, is assisted with meals, had lost more than 10# over 6 months, current BMI 27.4, representing over weight health status and had skin concerns. R41 needed assistance with meals, was to be offered a large glass of cranberry juice for meals due to recent urinary tract infection and pneumonia. R41 would wander around and leave the table if food or beverage were not present. The nutritional assessment did not identify R41's nutrition needs or if his current intakes were adequate for his condition.

9/23/15, R41 had multiple skin issues including pressure area on hip, blister on right heel and blackened big toe. R41 was also noted to have declining condition with more lethargy and drooling at times. R41 was on a regular diet, was independent with eating, weight 163 pounds,

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F 325	Continued From page 37 body mass index (BMI) 25.5 representing healthy weight status. Weight has decreased 7 pounds x 1 month, 8 pounds loss x 3 months. Has history of good intakes, however, does have varied intakes with some declined intakes at some meals. May benefit from larger meat serving and vitamin C to assist with iron status and absorption. May benefit from a NDS (nutritionally dense supplement) or other high calorie/protein foods to assist with weight stability due to healthy BMI and weight loss noted. The nutritional assessment did not identify R41's nutrition needs or what his current intakes were, or if current nutrition interventions were effective. 10/15/2015, R41 was on a regular diet, estimated intake from all food groups were 75-100%, BMI 25.8, weight 10/13, 165, 30 day weight loss 6 lbs. R41 would hold glass of beverage at meals, needed assistance to eat food. R41 did not make food choices known, referred to nursing skin note and R41 was to have additional fluids offered through-out the day by staff. Nutritional assessment did not identify R41's nutrition needs or if his current intakes were adequate for his condition. During interview with licensed practical nurse (LPN)-D on 10/21/15, at 1:59 p.m. LPN-D verified R41 had declined over the last few months. She stated the right heel ulcer had deteriorated and the pressure uler over the bunion was larger. LPN-D also stated R41 had eaten all of his breakfast that morning, but had not eaten any lunch because of the late breakfast. On 10/21/15, at 2:27 p.m. registered nurse (RN)-C stated R41 had developed a pressure ulcer to his left hip and right bunion on 8/30/15.	F 325		

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She further stated he had developed a pressure ulcer to his right heel on 9/16/15. RN-C confirmed there was no current order for R41 to receive a nutritional supplement, but stated she was aware of the recommendation to try a supplement. RN-C stated she must not have finished the consult request for the supplement, and confirmed she would have expected him to be placed on a supplement to assist with healing his wounds and to prevent further weight loss.

On 10/22/15, at 7:56 a.m. dietary associate (DA)-A stated R41's food consumption varied daily. She stated R41 usually did not come out of his room for breakfast until 9-9:30 a.m. and that she felt his eating breakfast later may affect how he ate lunch. DA-A said there was currenty nothing special being done for R41's nutritional status other than routine meals served from the kitchen. She stated she thought R41 had previously tried a nutritional supplement but wasn't sure, nor sure of why it had been discontinued. DA-A also stated R41 had previously been able to feed himself, but now required total staff assistance.

On 10/22/15, at 5:36 p.m. nursing assistant (NA)-D stated R41 had not been eating much for about a month. She stated she felt the kitchen staff might have changed his diet to a mechanical soft (ground) diet, but she wasn't sure. She also confirmed staff had started to assist R41 with eating. NA-D stated R41 had lost some weight, but was not sure whether nutritional supplements had ever been attempted.

On 10/22/15, at 5:40 p.m. LPN-A stated R41 hadn't been eating much lately and that she was aware he'd lost weight. She stated today at

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dinner R41 had hardly eaten anything even though she tried to feed him.

On 10/23/15, at 8:46 a.m. NA-I stated R41 was not eating well. She stated he required total feeding assistance but that he'd been able to feed himself up until 2-3 weeks ago. NA-I stated she thought R41 probably got some kind of a supplement drink, but wasn't sure. She stated she thought she had tried a supplement with him about a month ago.

On 10/23/15, at 8:51 a.m. during a follow up interview, DA-A stated between meal snacks are pretty much optional for residents. She stated R41 did not have any scheduled or planned snacks, nor did R41 ask for snacks or fluids between meals. DA-A stated she wasn't sure if the NAs offered him things between meals, or if R41 had anything to eat or drink in his room.

On 10/23/15, at 2:30 p.m. NA-F stated R41 had stopped feeding himself and had lost weight over the last month. She stated he was more lethargic, had been sleeping a lot more lately, and stated he would eat a snack when he was not too sleepy. NA-F stated she thought R41 received a nutritional supplement, but wasn't sure.

Review of R41's Dietary Intake Form, completed for 7 days during the assessment period 10/8 thru 10/14/15, indicated R41 generally ate a good breakfast, and drank juice. Intake documentation for the noon meal indicated R41's meal intake varied, but that R41 generally ate less at the noon meal. The noon meal documentation also indicated R41 was not routinely offered juice at that meal. Documentation for the evening meal indicated R41 ate between half and all of his

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F 325	Continued From page 40 protein, and had been offered juice 3 of 7 days. On 10/23/15, at 4:08 p.m. the director of nursing (DON) stated she would expect the RN case manager to change interventions if current interventions were not effective, and to obtain new treatment orders from the physician. The DON stated for residents with a skin issue she would expect staff to request an order for a nutritional supplement. She stated if a resident didn't like a nutritional supplement after it had been attempted, she would expect staff to consider an alternative supplement. The DON also stated when the registered dietitian (RD) completed a nutritional assessment she'd send an email to the case manager, and the case manager was expected to follow up with the RD's recommendations, and obtain physician orders as needed. The DON acknowledged the facility had not followed up on the RD's recommendations for the nutritional supplement intervention for R41. On 10/27/15, at 10:27 a.m. the Dietary Director stated she was aware R41 had new and worsening pressure ulcers. She indicated she had been encouraging him to eat more protein and drink more juice with vitamin C. She stated this had not been very successful. The dietary director also stated the facility's usual practice was that when a registered dietitian (RD) recommended supplements, nursing would try alternatives if a resident was not accepting of the specific supplement. The dietary director stated she thought R41's current interventions included; increased protein, juice with vitamin C, and larger servings of food. She stated the usual practice was to have a "kitchen meeting" where she would provide direction for staff as to what to serve a resident for meals. However, the dietary director	F 325		

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F 325	Continued From page 41 couldn't remember whether a meeting had been held to instruct staff on R41's dietary needs. In addition, the dietary director stated she was aware R41 had experienced weight loss at admission and after his emergency room visit. However, she verified she'd made no changes to R41's nutritional interventions. She stated she'd thought R41 was receiving a nutritional supplement, and that she'd expect a resident with pressure ulcers and weight loss to receive one. She said she was surprised R41 did not routinely receive a supplement. The dietary director also confirmed the facility monitored food intake for 5-7 days quarterly at the time a review was due, and confirmed R41 otherwise had no ongoing food intake monitoring being done. The facility's Skin Care Policy revised 6/23/14, identified the RD would assess and recommend approaches to increase calories, protein, fluids, vitamins and minerals, based on the needs of the resident. The policy indicated the RD would document any initial nutrition intervention plan, and follow up in the progress notes monthly or as changes were made. The policy indicated nutrition approaches would also be documented in the care plan, and if a resident was at nutritional risk the RD would recommend and implement additional calories, protein and fluids at or between meals, document acceptance of meals and nourishments, obtain a physician's order for nutritional supplement and monitor resident weights.	F 325		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or	F 353		12/4/15

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F 353	Continued From page 42 maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and document review the facility failed to ensure sufficient staffing in the facility was available to meet resident needs related to prevention and treatment for pressure ulcers (R41), assistance with ambulation (R39) and ROM services for (R1). This deficient practice had the potential to affect all 58 residents currently residing in the facility. Because of the deficient practice, the facility caused actual harm for R41, R39 and R1. Findings include: R41's significant change Minimum Data Set (MDS) dated 10/13/15 identified R41 had severe	F 353	It is the policy of Minnewaska Lutheran Home that sufficient nursing staff are available to meet the needs of the residents. The Director of Nursing or her designee are responsible to ensure that sufficient staffing is available to meet the resident's needs. 1. Minnewaska Lutheran Home does provide sufficient 24-hour nursing staff to meet the needs of the residents. 2. Administration has reviewed the workflow of the staff to meet the needs of the residents. An additional LPN has been hired and continue to recruit for any open positions. 3. Current and new staff will be educated	

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F 353	Continued From page 43 cognitive impairment, had physical behaviors, was not rejecting care, required extensive assistance with activities of daily living(ADL's) and was always incontinent of bowel. R41's MDS further indicated R41 had developed 2, stage II pressure ulcers and 1 unstageable pressure ulcer, and was at risk for the development of further pressure ulcers. R41 did not receive timely repositioning as directed by the care plan due to insufficient staffing, see F314 R39's quarterly MDS dated 9/9/15, identified R39 was cognitively intact and needed extensive assistance from staff with ADL's which included ambulation services with the facility restorative nursing assistant (RA.) On 10/19/15, at 5:46 p.m. R39 stated staff was unable to assist with ambulation as there was not enough staff available. R39 further stated the staff stopped ambulating with her close to a month ago as there were not enough of them to help. R39 stated did not like to complain as the staff worked too hard as it was. R39 did not receive ambulation services as directed by the care plan due to insufficient staffing, see F 310 R1's quarterly MDS dated 7/29/15, identified R1 had moderately impaired cognition and had diagnoses which included quadriplegia (loss of voluntary movement to extremities), cerebral vascular accident (CVA) with aneurysm and cerebral bleed (blood clot which had ruptured in the brain.) The MDS also identified R1 needed total assistance of two staff with ADL's and had	F 353	on providing cares per the resident's care plans. 4. Audits of resident's care with staff will be completed on a daily basis by DON or designee. Monitoring to ensure compliance will be completed through daily review of the schedule. Results of the audits will be brought to the Quality Assurance Committee to review and for recommendations.	

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	245537	A. BUILDING _____ B. WING _____	10/23/2015

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F 353	Continued From page 44 limited functional range of motion (ROM) to both upper and both lower extremities. R1 did not receive ROM services as directed by the care plan due to insufficient staffing, see F 317. On 10/21/15, at 3:15 p.m. the restorative aid (RA) stated she was often removed form her role as a RA to work as a nursing assistant (NA) providing direct cares to residents due to staffing shortages. The RA indicated the residents restorative therapy would not get done the way it should when she worked as an NA. The RA stated on average she spent half of her scheduled days as a floor NA and not as a RA. The RA stated she would try to see the residents who needed ROM services even if she was pulled to the floor as she did not want them to lose their abilities. However, the RA stated this did not always work out and when was able to work with them it was for a shorter amount of time. The RA indicated she would try to complete ROM on residents when she assisted them in getting dressed in the morning when she was not able to work as a RA. The RA also stated residents ask about the exercise class she would hold mid mornings and felt bad when she could not coordinate the exercise class. The RA stated many NA's and LPN's often worked 12 to 16 hour shifts and she had noticed some staff showing signs of burnout. The RA stated some staff would get grumpy with residents, but would feel bad and they were so exhausted. The RA confirmed residents had lost abilities such as ambulation for R39, R60 and loss of range of motion (ROM) for R1, R24, R27, R49, R40, due to the lack of restorative services. The RA stated she tried to get the residents back to where they were before	F 353		

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F 353	Continued From page 45	F 353		

the staffing shortage but has been unable as she continued to be pulled to the floor.

R60's quarterly MDS, dated 8/6/15, identified R60 had intact cognition, and required extensive assistance with toileting, dressing, transferring, bed mobility and did not ambulate.

On 10/22/15, at 6:34 p.m. R60 indicated there was not enough staff in the facility to assist him with cares. R60 indicated he would put on his call light and it often took someone 30 minutes to show up, R60 stated this often occurred on the day and evening shift.

On 10/21/15, at 5:19 a.m. licensed practical nurse (LPN)-C indicated she was not able to monitor or oversee the care of residents nor did she monitor care to ensure cares were being completed timely. LPN-C indicated 3 staff members often worked the night shift and they each had a wing to work on.

On 10/21/15, at 5:28 a.m. TMA-A stated the D-wing primarily had residents who were severely cognitively impaired and needed assistance of two staff with cares and positioning. TMA-A indicated there were times she/he had to complete every two hour rounds on her own, which included repositioning residents by herself. The TMA-s further indicated she tried not to deviate from the residents care plan and stated, "we have to get the rounds done, so what are we supposed to do." TMA-A stated they had been told to "get by" with the staff they had.

On 10/21/15, at 8:30 a.m. registered nurse (RN)-C stated R41 had not been repositioned timely that morning because they were struggling

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F 353	Continued From page 46 with staffing. She stated they had been struggling with staffing and short NA's since August. On 10/21/15, at 1:51 p.m.. LPN-D indicated she was unable to complete her duties of monitoring resident cares and assist on the floor as needed. LPN-D stated they often worked short staffed and were expected to "re-adjust." On 10/21/15, at 1:50 p.m. NA-A indicated she/he was not able to give the residents the care they needed due to short staffing. NA-A stated residents, such as R41, were not repositioned when needed due to staffing shortages. NA-A indicated the NA's were often mandated 16 hour shifts and the hours had become overwhelming. NA-A also indicated she/he had seen signs of "burnout" in herself/himself and others. NA-A stated the facility had been short staffed for at least a month. NA-A indicated the RA was often was pulled from restorative duties to work as a floor aid. NA-A stated it was heartbreaking to know the residents were not getting the care they deserve to get and the remaining staff continued to work in the facility out of concern for the residents. NA-A stated working a night shift could be "down right scary" when there are only three staff on as some residents could get physical and often times needed more than one staff to assist with the resident. NA-A stated more often than not there were only two NA's on the D wing and they were told if the other NA was on break and the one left on the floor needed help with transferring a resident (who needed assist of two,) they were supposed to ask anyone (even the janitor) to run the lift controls on the mechanical lift. Further, NA-A indicated there were many resident tasks the non-direct care staff would not be trained to assist with. NA-A	F 353		

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F 353	Continued From page 47 stated they had been told to work with what they had even if they only had one NA on the floor. NA-A also stated the NA's were not given updates on resident changes, especially if they were working on a different wing it would be up to them to find out if the residents had any changes since the last time they worked on the wing. NA-A stated the facility administration had not updated the NA's on the facilities plans or progress of finding more staff. On 10/21/15, at 2:29 p.m. LPN-H stated the facility did not have enough staff to provide resident cares as they needed. LPN-H stated staff often worked 12 to 16 hours a day and they were often working with two NA's on the D wing and sometimes one NA on the other wings. LPN-H stated there were some residents who had a history of being combative and was concerned for the resident and staff safety should they be alone on the night shift. LPN-H stated she was aware medications were administered late due to the medication nurse assisting with resident cares when there were not enough NA's on the wing. LPN-H also stated the D wing needed three NA's due to residents wandering, aggression, combativeness with cares and the need for time to provide therapeutic re-direction. LPN-H stated the director of nursing (DON) and administration had not asked direct care staff about staffing concerns. On 10/22/15, at 8:30 a.m. registered nurse (RN)-A stated they had been short staffed for a period of time after seven NA's had quit, all at approximately the same time. On 10/22/15, at 10:21 a.m. the administrative assistant (AA) stated she was responsible for	F 353		

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F 353	Continued From page 48 developing the facility's master schedule. The AA stated she would get the staffing ratios from the administrator when they changed. The AA stated she usually dealt with any sick calls if they came in while she was there during the day and was usually able to find a replacement. The AA stated if the sick call came in later it was up to the floor nurses to find a replacement. The AA stated she generally tried to staff the facility as follows: -night shift, two licensed staff were scheduled from 6:30 p.m. to 6:00 a.m. though one of the licensed could be a TMA, one NA on each wing from 10:30 p.m. to 7:00 a.m. (total of 3 NA's.) -day shift, one licensed staff on each wing (may have a TMA) from 6:00 a.m. to 6:30 p.m. , two NA's on A/B and C wing and three on the D wing ROM 6:00 a.m. to 2:30 p.m. total of 7 NA's. -evening shift, the licensed staff were scheduled for the am and night shift, two NA's on A/B wing and three on the D wing from 2:15 p.m. to 10:45 p.m. and an NA for a shorter shift from 4:00 p.m. to 10:30 p.m. Review of the facilities daily assignments sheets from 9/12/15 to 10/23/15, revealed the facility did not consistently have the staffing ratios the administrator had directed. The following inconsistencies were found: - the day shift did not have the staffing determined by the administrator for 38 out of 42 days - the evening shift did not have the staffing determined by the administrator for 40 out of 42 days - the night shift did not have the staffing	F 353		

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F 353	Continued From page 49 determined by the administrator for 27 of 42 days, in addition there were 3 night shifts with 3 or less staff. On 10/22/15, at 2:14 p.m. LPN-E stated she felt the facility staff was not sufficient to consistently meet residents needs. LPN-E indicated the RA was not able to complete resident restorative programs when she was removed from restorative duties. LPN-E indicated she had noticed a decline in R1, R4 and R40's ROM since the RA had been unable to complete residents restorative programs consistently. LPN-E stated the residents did not receive the attention and time from staff they needed and she was unable to monitor resident care when they were short staffed. LPN-E also stated residents were aware when there were not enough staff, such as R39 and R60. LPN-E indicated she had spoken with the DON about staffing concerns. however, she also indicated the changes the DON and administrator had tried had not worked and she was not aware of any other changes the DON and administrator were doing to improve staffing at the present time other than not admitting new residents. On 10/22/15, at 3:18 p.m. during a follow up interview, RN-A stated she knew the DON and administrator were very aware of the facilities lack of staff, however the staffing shortages were ongoing. On 10/22/15,at 3:37 p.m.. the DON indicated the guidelines for staffing the facility used was based upon the census, 58 residents would get 203 nursing hours. The DON stated the administrator had set the guidelines for staffing. The DON	F 353		

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F 353	Continued From page 50 indicated it was unacceptable to have had three staff work the overnight shift. The DON indicated she was aware R60 and his wife had directly complained about the staffing shortage to the administrator within the last few months. The DON also indicated she had received complaints from staff on a daily basis about the staffing shortage and staff had reported feeling overworked. The DON stated she was aware resident care plans were not being followed consistently. The DON confirmed the facility had experienced staffing shortages since August 2015 and had stopped admitting residents to the facility at that time. The DON confirmed the attempts thus far had not been successful in obtaining and retaining staff for resident care. The DON stated the facility was currently not accepting admissions and was working on a plan which would be effective January 2016, however, they did not have an immediate plan in place for the facility's current staffing needs. The DON indicated the facility did not plan on transferring residents out of the facility due to staff shortages and indicated she expected the census to decrease in the future due to discharges/deaths. The DON confirmed the facility had insufficient staffing levels at times. The DON stated she had discussed the staff shortages several time with the administrator in the past and was he aware of the staffing concerns. On 10/23/15, at 11:14 a.m. the administrator stated he felt the staff were overworked, though he did not feel there were staffing concerns. The administrator stated he felt staffing levels were adequate on all shifts in the facility. The administrator stated he would be comfortable with a one staff to twenty resident ratio, therefore he would feel safe with three staff caring for 58	F 353		

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F 353	Continued From page 51 residents. The administrator denied any family complaints of staffing, however, indicated facility staff had complained about staffing levels. The administrator stated he felt staff complaints were more morale based and not due to insufficient staffing. The administrator confirmed he was aware of resident care plans were not consistently followed, however, he felt resident care plans not being followed had been a result of poor performance by staff instead of insufficient staffing. The administrator indicated all staff performance evaluations were completed annually and indicated the facility had not completed staff evaluations due to poor performance in the recent past. The administrator indicated the nurse managers and LPN's were responsible for monitoring cares on a daily basis. The administrator stated he felt residents were getting the care and assistance they needed with the staff they had at present. The administrator indicated he routinely walked thru the facility, to make himself visible to staff and residents. On 10/23/15, at 2:13 p.m. NA-C stated there were not enough staff to complete cares timely on a consistent basis. NA-C stated many staff were putting in too many hours and were experiencing burnout. NA-C stated she/he had spoken directly to the administrator and informed him R21 had not received assistance with using a urinal and R21 was upset about it. NA-C stated R21 had told her/him no one talked to him about it afterwards. NA-C indicated when staff called in sick the facility often were not able to replace them and the remaining staff ended up working short staffed. NA-C stated she/he felt at times staffing levels were unsafe. NA-C confirmed the RA had often been removed from the restorative role to work on the floor and residents would not	F 353		

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F 353	Continued From page 52 receive ambulation and ROM exercises. NA-C also confirmed R39's ambulation ability had declined and residents such as R1, R4, R40 and R24 had increased stiffness when ROM exercises were not done.	F 353		
F 458 SS=E	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure the single resident rooms on the A-wing of the facility had at least 100 square feet of useable floor space for 13 of 15 rooms. This affected 13 of 13 residents (R13, R15, R23, R26, R29, R30, R34, R35, R37, R47, R53, R56, R61) who resided in the rooms. Findings include: During tour of the A-wing on 10/22/15, at 2:00 p.m. resident rooms 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35 and 36 were observed to not have at least 100 square feet of useable floor space. On 10/22/15, at 2:36 p.m. R34 reported there were no concerns with the room size and reported no difficulty moving around in the wheelchair. On 10/22/15, at 2:41 p.m. R13 stated she liked her room, would not want to switch room and had	F 458	Waiver requested: in rooms 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, and 36 are 95.68 to 96.07 square feet of usable space and do not meet the minimum requirements of at least 100 square feet of usable space. Formally complying bedrooms were reduced in areas to accommodate expanded toilet rooms. A previous similar waiver was requested.	11/16/15

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F 458	Continued From page 53 no complaints. On 10/22/15, at 2:42 p.m. R53 stated he liked his room, and reported was able to move around with no difficulty. On 10/22/15, at 2:43 p.m. R23 was observed in bed with a safety mat on the floor next to the bed, R23 had no complaints regarding the room size. All rooms were noted to be clean, orderly, and decorated. On 10/22/15, at 2:38 p.m. the facility environmental services director (ESD) stated the single rooms on the A-wing were less than the required 100 square feet of useable floor space, and the facility would be applying for a room wavier. The ESD reported the housekeeping staff were able to complete the cleaning tasks without difficulty. On 10/22/15, at 2:39 p.m. nursing assistant (NA)-B stated the rooms are smaller on the A-wing, however, there were no difficulties taking care of residents due to the room sizes, even when mechanical lifts are utilized. On 10/22/15, at 2:53 p.m. the administrator confirmed the rooms on the A-wing continue to have less than 100 square feet of usable space and indicated the facility would be applying for the waiver for this issue.	F 458		
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and	F 490		12/4/15

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F 490	Continued From page 54 efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility's administrator and director of nursing (DON) failed to adequately oversee care and provide sufficient nursing staff to ensure care and services were provided for pressure ulcer treatment, ambulation and range of motion (ROM) for residents. Three residents were determined to have sustained actual harm as a result of this deficient practice (R1, R41 and R39). The failure to provide adequate and effective oversight had the potential to affect all 58 residents living in the facility. Findings include: Harm level deficiencies were issued regarding provision of care to residents to ensure that: -their ability to ambulate does not diminish unless the decline was determined unavoidable -appropriate treatment and services to maintain and/or prevent further decrease in range of motion is provided for residents that have identified limitations in range of motion -those residents having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Refer to F310: R 39, due to staff shortage, did not receive consistent restorative services which resulted in a decline in ability to ambulate.	F 490	The Administrator is ultimately responsible for the day to day function and oversight of the facility and assure the facility remains in compliance to ensure adequate supervision and sufficient nursing staff to ensure care and services were provided for the residents. A plan of correction has been developed and the alleged deficient practices have had a plan of correction developed and will be sustained per the administrator's oversight. The Administrator is responsible to oversee that the survey audits and plan of correction results are reviewed on a weekly basis.	

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F 490	Continued From page 55 Refer to F314: R 41, due to staff shortage, did not receive appropriate care and services (including timely repositioning) to prevent pressure ulcer development and promote healing of pressure ulcers. Refer to F318: R1, due to staff shortage, did not receive consistent range of motion (ROM) services which resulted in loss of ROM. Refer to F353: The facility did not provide sufficient nurse staffing to ensure residents received care per their individualized plans of care. On 10/22/15,at 3:37 p.m. the director of nursing (DON) indicated the guidelines for staffing the facility used was based upon the census, 58 residents would get 203 nursing hours. The DON stated the administrator had set the guidelines for staffing. The DON indicated it was unacceptable to have had three staff work the overnight shift. The DON indicated she was aware R60 and his wife had directly complained about the staffing shortage to the administrator within the last few months. The DON also indicated she had received complaints from staff on a daily basis about the staffing shortage and staff had reported feeling overworked. The DON stated she was aware resident care plans were not being followed consistently. The DON confirmed the facility had experienced staffing shortages since August 2015 and had stopped admitting residents to the facility at that time. The DON confirmed the attempts thus far had not been successful in obtaining and retaining staff for resident care. The DON stated the facility was currently not accepting admissions and was working on a plan which would be effective January 2016, however,	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245537	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEWASKA COMMUNITY HEALTH SERVICES	605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 56	F 490		

they did not have an immediate plan in place for the facility's current staffing needs. The DON indicated the facility did not plan on transferring residents out of the facility due to staff shortages and indicated she expected the census to decrease in the future due to discharges/deaths. The DON confirmed the facility had insufficient staffing levels at times. The DON stated she had discussed the staff shortages several times with the administrator in the past and was he aware of the staffing concerns.

On 10/23/15, at 11:14 a.m. the administrator stated he felt the staff were overworked, though he did not feel there were staffing concerns. The administrator stated he felt staffing levels were adequate on all shifts in the facility. The administrator stated he would be comfortable with a one staff to twenty resident ratio, therefore he would feel safe with three staff caring for 58 residents. The administrator denied any family complaints of staffing, however, indicated facility staff had complained about staffing levels. The administrator stated he felt staff complaints were more morale based and not due to insufficient staffing. The administrator confirmed he was aware of resident care plans were not consistently followed, however, he felt resident care plans not being followed had been a result of poor performance by staff instead of insufficient staffing. The administrator indicated all staff performance evaluations were completed annually and indicated the facility had not completed staff evaluations due to poor performance in the recent past. The administrator indicated the nurse managers and LPN's were responsible for monitoring cares on a daily basis. The administrator stated he felt residents were getting the care and assistance they needed with

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	245537	A. BUILDING _____ B. WING _____	10/23/2015

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F 490	Continued From page 57 the staff they had at present. The administrator indicated he routinely walked thru the facility, to make himself visible to staff and residents.	F 490		

Minnewaska Community Health Services

a community of services grounded in faith

November 9, 2015

Gail Anderson, Unit Supervisor
Minnesota Department of Health
1505 Pebble Lake Road #300
Fergus Falls, Minnesota 56537

Dear Ms. Anderson:

Please accept this letter as our request to ask for a Federal waiver for the deficiency cited during our standard state survey completed by the Minnesota Department of Health and Public Safety on October 23, 2015. The waiver request is in response to the following Federal Deficiency:

1. F 458 483.70 (d)(1)(ii) Bedrooms Measure at least 100 Sq. Feet for one bed, private bedrooms.

A waiver has been previously reviewed and approved at the Minnesota Department of Health.

A Wing rooms: 24,25,26,27,28,29,30,31,32,33,34,35 and 36

The facility recognizes that the square footage in the A wing for the private one bed rooms noted are between 95.68 to 96.07 square feet and will work to address the comments/concerns noted by residents in the deficiency.

A previous remodeling and expansion of the toileting rooms on the "A" wing resulted in a slightly reduced useable floor area in the rooms thus the need for a waiver.

If you have any questions or concerns, please feel free to contact me.

Sincerely,

Chris Knoll, Administrator
Minnewaska Community Health Services
Phone: (320) 239-7104 Email: cknoll@mchs-healthcare.org

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245537	A. BUILDING **01 - 01 - 1960 BUILDING AND ADDITIONS** B. WING _____	**10/20/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEWASKA COMMUNITY HEALTH SERVICES	**605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on October 20, 2015. At the time of this survey, Building 01 of Minnewaska Community Health Services Nursing Home was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division	K 000	EPOC	

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

Electronically Signed | 11/18/2015

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

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MINNEWASKA COMMUNITY HEALTH SERVICES	**605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381**

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K 000	Continued From page 1 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Building 01 of Minnewaska Community Health Services Nursing Home is a one-story building with no basement, and is fully fire sprinkler protected throughout. The original 1960 building along with the 1968 and 1972 additions were determined to be of Type II(111) construction. The 1988 and 1996 building additions were determined to be of Type V(111) construction. The 2000 building addition was determined to be of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 65 beds and had a census of 58 at time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect all patients, visitors and staff of the facility. Findings include: On facility tour between 9:30 AM and 1:30 PM on 10/20/2015, observations reveled that the spare sprinkler head box was not equipped with at least	K 056	Nova Sprinkler Company has provided 2 new sprinkler heads on 10/28/2015. They will be stored in the water treatment room E 109. This will be monitored by the Environmental Service Director for compliance.	10/28/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 056	Continued From page 3 2 of every type and style of sprinkler heads that are being used in the facility. This deficient practice was verified by the Facility Administrator (CK).	K 056		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect all 58 residents, staff and visitors. Findings include: On facility tour between 9:30 AM and 1:30 PM on 10/20/2015, a review of documentation and interview with the Facility Administrator (CK), revealed the facility failed to provide documentation for the annual fire sprinkler test as	K 062	Nova Sprinkler Company was notified to not have annual sprinkler test to not exceed 360 days from the last test. This was verified by Nova Sprinkler Service Technician. The annual test date has been scheduled for August 15, 2016 This will be continually monitored by the Environmental Service Director	10/28/15

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K 062	Continued From page 4 required by NFPA 13(99) and NFPA 25(98). The fire sprinkler annual test/inspection was not conducted within the 365 day requirement. This deficient practice was verified by the Facility Administrator (CK).	K 062		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245537	A. BUILDING **02 - 02 - 2004 ADDITIONS** B. WING _____	**10/20/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on October 20, 2015. At the time of this survey, Building 02 of Minnewaska Community Health Services Nursing Home was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	EPOC	

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K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Building 02 of Minnewaska Community Health Services Nursing Home consists of the 2004 building addition, and is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type V(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 65 beds and had a census of 58 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 056		10/28/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 056	Continued From page 2 There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5. This STANDARD is not met as evidenced by: Based on observations and staff interview, it was found that the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect 120 of 120 residents, visitors and staff of the facility. Findings include: On facility tour between 9:30 AM and 1:30 PM on 10/20/2015, observations reveled that the spare sprinkler head box was not equipped with at least 2 of every type and style of sprinkler heads that are being used in the facility.	K 056	Nova Sprinkler Company has provided 2 new sprinkler heads on 10/28/2015. They will be stored in the water treatment room E 109. This will be monitored by the Environmental Service Director for compliance.	

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K 056	Continued From page 3 This deficient practice was verified by the Facility Administrator (CK).	K 056		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 18.3.4.1 and 9.6, as well as 1998 NFPA 25, section 2-2.1.1. The deficient practice could affect all patients, staff, and visitors. Findings include: On facility tour between 9:30 AM and 1:30 PM on 10/20/2015, a review of documentation and interview with the Facility Administrator (CK), revealed the facility failed to provide documentation for the annual fire sprinkler test as required by NFPA 13(99) and NFPA 25(98). The fire sprinkler annual test/inspection was not conducted within the 365 day requirement. This deficient practice was verified by the Facility Administrator (CK).	K 062	Nova Sprinkler Company was notified to not have annual sprinkler test to not exceed 360 days from the last test. This was verified by Nova Sprinkler Service Technician. The annual test date has been scheduled for August 15, 2016 This will be continually monitored by the Environmental Service Director	10/28/15