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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: PWHV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00351

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245263**

2.STATE VENDOR OR MEDICAID NO.
(L2) **909545400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GLENCOE REGIONAL HEALTH SERVICES**
(L4) **1805 HENNEPIN AVENUE NORTH**
(L5) **GLENCOE, MN** (L6) **55336**

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 **11/03/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **110** (L18)

13.Total Certified Beds **110** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	110			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Holly Kranz, HFE NE II — 11/03/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 12/15/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/26/1983
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 12/16/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/03/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245263

Electronically delivered November 13, 2014

Mr. Jon Braband, Administrator
Glencoe Regional Health Services
1805 Hennepin Avenue North
Glencoe, Minnesota 55336

Dear Mr. Braband:

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 the above facility is certified for or recommended for:

110 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 110 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

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

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
November 13, 2014

Mr. Jon Braband, Administrator
Glencoe Regional Health Services
1805 Hennepin Avenue North
Glencoe, Minnesota 55336

RE: Project Number S5263023

Dear Mr. Braband:

On September 26, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 18, 2014. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On November 3, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on October 15, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 18, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 20, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 18, 2014, effective October 20, 2014 and therefore remedies outlined in our letter to you dated September 26, 2014, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245263	A. Building B. Wing	11/3/2014

Name of Facility	Street Address, City, State, Zip Code
GLENCOE REGIONAL HEALTH SERVICES	1805 HENNEPIN AVENUE NORTH GLENCOE, MN 55336

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	**10/14/2014**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	**10/20/2014**	ID Prefix **F0247** Reg. # **483.15(e)(2)** LSC	**10/01/2014**
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:
Reviewed By State Agency	JS/KJ	11/13/2014	33561	11/3/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 9/18/2014

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	(Y3) Date of Revisit
245263	A. Building 01 - MAIN BUILDING 01 B. Wing	10/15/2014

Name of Facility	Street Address, City, State, Zip Code
GLENCOE REGIONAL HEALTH SERVICES	1805 HENNEPIN AVENUE NORTH GLENCOE, MN 55336

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 Reg. # NFPA 101 LSC K0011	Correction Completed 09/20/2014	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 PS/KJ	Date: 11/13/2014	Signature of Surveyor: 22373	Date: 10/15/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 9/19/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

AH Form Approved

12/15/2014

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00351	A. Building B. Wing	11/3/2014

Name of Facility	Street Address, City, State, Zip Code
GLENCOE REGIONAL HEALTH SERVICES	1805 HENNEPIN AVENUE NORTH GLENCOE, MN 55336

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **21995** Reg. # **MN St. Statute 626.557 Subd. 4** LSC	**10/20/2014**	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		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** JS/KJ	**Date:** 11/13/2014	**Signature of Surveyor:** 33561	**Date:** 11/3/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 9/18/2014		**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: PWHV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00351

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245263**

2.STATE VENDOR OR MEDICAID NO.
(L2) **909545400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GLENCOE REGIONAL HEALTH SERVICES**
(L4) **1805 HENNEPIN AVENUE NORTH**
(L5) **GLENCOE, MN** (L6) **55336**

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 **09/18/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **110** (L18)

13.Total Certified Beds **110** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With
Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	110			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Christi Bodick-Nord, HFE NE II 10/13/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 10/31/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/26/1983
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 26, 2014

Mr. Jon Braband, Administrator
Glencoe Regional Health Services
1805 Hennepin Avenue North
Glencoe, Minnesota 55336

RE: Project Number S5263023

Dear Mr. Braband:

On September 18, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

attached deficiencies.

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

DEPARTMENT CONTACT

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

Jessica Sellner, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7365
Fax: (320)223-7365

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 October 28, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

- Include dates when corrective action will be completed. The corrective action

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by December 18, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 18, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process

Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting 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:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245263	A. BUILDING _____ B. WING _____	09/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENCOE REGIONAL HEALTH SERVICES	1805 HENNEPIN AVENUE NORTH GLENCOE, MN 55336

(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 On September 15, 16, 17, and 18, 2014, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and	F 225		10/14/14

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

Electronically Signed | 10/02/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245263	A. BUILDING _____ B. WING _____	09/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENCOE REGIONAL HEALTH SERVICES	1805 HENNEPIN AVENUE NORTH GLENCOE, MN 55336

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F 225	Continued From page 1 misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to investigate and immediately report to the state agency (SA) and facility administrator an allegation of verbal abuse for 1 of 1 resident (R147) reviewed who made allegations of verbal abuse by a staff member. Findings include: R147's admission Minimum Data Set (MDS) dated 9/3/14, indicated R147 was cognitively intact. R147's care plan dated 9/16/14, indicated R147 required assistance with toileting and was incontinent of bowel and bladder.	F 225	It is the intent of Glencoe Regional Health Services LTC facility to ensure that all allegations of abuse and neglect are reported to the administrator, OHFC, and the CEP immediately. A vulnerable adult report was submitted and investigated by the Director of Nursing (DON) on R147 with notice from OHFC that no further action was necessary. The facility's Vulnerable Adult/Abuse Policy and reporting procedure has been reviewed and no changes are indicated at this time. On 9/24/14, the DON re-in	

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F 225	Continued From page 2 During interview on 9/17/14, at 2:03 p.m. R144, who was R147's roommate, stated a staff member had come into her room during the night screaming and yelling at her roommate, R147. R144 stated the staff yelled at R147 they had already been down to answer the call light five times. R147 asked if staff would check her brief because she thought she was wet. Staff told R147 if she did not stop turning the call light on and settle down they would get her up and bring her to the front desk. R144 reported the staff member stated to R147, "You left me a good old package," meaning a bowel movement. R144 was unable to identify the staff member who yelled at R147, but stated it was a, "night shift girl," and the incident happened about a week ago. R144 stated she reported the incident to LPN-A the next morning, however, she had not heard anything since and no one from the facility came and talked to her about the incident. During interview on 9/17/14, at 3:16 p.m. R147 stated she was verbally abused by a staff member about a week ago. R147 stated the staff came into her room and yelled at her because she was using her call light too often and if she didn't stop they were going to make her come down by the nurses station. R147 stated she didn't want to go to the nurses station because she had diarrhea. R147 stated another staff member who overheard the yelling told R147 the staff member used a very loud voice and that is not the way you should talk to someone. R147 stated the staff member was yelling at her so loud it woke her roommate up (R144). R147 could not identify the staff member who had yelled at her and stated she did not report it because she knew her roommate, R144, had told LPN-A about	F 225	serviced the full-time and part-time nursing staff on the facility's Vulnerable Adult/Abuse Policy/Procedure. The facility will report any event that is reportable under the State or Federal law per regulation to the administrator, OHFC, and the CEP immediately. Social Services will continue to review the Vulnerable Adult/Abuse Policy and reporting procedure annually and as needed with any changes in regulation. New employee orientation training includes the Vulnerable Adult Abuse and Neglect Policy. An annual Abuse & Neglect net learning module will be completed by all employees. The DON or designee will conduct Quality Assurance/Quality Improvement audits to ensure continued compliance regarding reporting allegations of abuse. Audits will be weekly for three months and/or until 100% compliance is achieved. The DON or designee will report the results of the audits to the QAPI Committee for review and follow-up action if needed. Submitted for Jon D. Braband, President & CEO	

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F 225	Continued From page 3 it the next morning. R147 stated no one at the facility spoke to her about the incident. During interview on 9/17/14, at 4:00 p.m. director of nursing (DON) stated she was not aware of R147's allegation of verbal abuse, therefore the facility had no investigation and it was not reported to the SA or administrator. DON stated LPN-A did not report this to her or anyone else at the facility she was aware of. DON stated LPN-A should have reported this to the charge nurse, DON, administrator, or social worker so a report and investigation could have been started immediately. During interview on 9/17/14, at 4:17 p.m. registered nurse (RN)-A stated all allegations of abuse are reported to her, and LPN-A had not reported the allegation of verbal abuse by R147. LPN-A was unavailable to be interviewed during the survey. Review of the facility's Vulnerable Adult/ Abuse Prohibition Plan and Prevention Policy dated 12/2013, instructed allegations of abuse were reported immediately to the administrator of the facility, and state agency.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		10/20/14

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F 226	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement the Abuse Prohibition Plan and Prevention Policy for 1 of 1 resident (R147), who made an allegation of verbal abuse by staff. In addition, the facility failed to ensure 1 of 5 newly hired employees, housekeeper (H)-A, had reference checks completed. Findings include: Review of the facility's Vulnerable Adult/ Abuse Prohibition Plan and Prevention Policy dated 12/2013, instructed allegations of abuse were reported immediately to the administrator of the facility and state agency. The policy also instructed all staff members will be screened as part of the pre-employment process and human resources will attempt to obtain information by checking a minimum of two references, including previous and/or current employers, and the results will be filed in their personnel files. R147's admission Minimum Data Set (MDS) dated 9/3/14, indicated R147 had no cognitive impairment. R147's care plan dated 9/16/14, indicated R147 required assistance for toileting and was incontinent of bowel and bladder. During interview on 9/17/14, at 2:03 p.m. R144 stated a staff member had come into her room during the night screaming and yelling at her roommate, R147. R144 stated staff screamed at R147 stating they had already been down to answer the call light five times. R147 asked staff if they would check her brief because she thought	F 226	GRHS has written policies and procedures for screening and training employees, protection of residents, and for prevention, identification, investigation, and reporting of abuse, neglect, mistreatment and misappropriation of property. The Vice President of Human Resources updated the GRHS Vulnerable Adult Abuse Prohibition Plan and Prevention Policy to include the 226 Federal requirement language of screening all applicants by obtaining information from previous or current employers and checking with the appropriate licensing boards and registries. On 10/2/14 a staff meeting was held with Human Resources staff to review the F226 Federal requirements. A new process was developed where the Human Resources Representative will screen all candidates by conducting and documenting attempts to obtain information from previous and/or current employers. If one or fewer previous employer references are provided by the candidate, attempts will be made to contact at least one personal reference. All copies of this information will be kept in personnel files. The Vice President of Human Resources will conduct a random audit of this process for the first three months to ensure compliance. Ongoing audits will	

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F 226	Continued From page 5 she was wet. Staff stated to R147 if she did not stop turning the call light on and settle down they would get her up and bring her to the front desk. R144 reported the staff member stated to R147, "You left me a good old package," meaning a bowel movement. R144 was unable to identify the staff member who yelled at R147, but stated it was, "the night shift girl," and the incident happened about a week ago. R144 stated she reported the incident to LPN-A the next morning, however, she had not heard anything and no one came and talked to her about the incident. During interview on 9/17/14, at 3:16 p.m. R147 stated she was verbally abused by a staff member about a week ago. R147 stated a staff member came into her room and yelled at her because she used her call light too often. The staff member told R147 if she didn't stop turning on the call light, they were going to make her come down by the nurses station. R147 stated she didn't want to go because she had diarrhea. R147 stated a staff who overheard the other staff member yelling at her had used a very loud voice and it is not a way you should talk to someone. R147 stated the staff member was yelling at her so loud it woke her roommate up (R144). R147 could not identify the staff member who yelled at her and stated she did not report it because she knew her roommate, R144, had told LPN-A about it the next morning. R147 stated no one at the facility spoke to her about the incident. During interview on 9/17/14, at 4:00 p.m. the director of nursing (DON) stated she was not aware of R147's allegation of verbal abuse by a staff member, therefore the facility had no investigation, nor was the administrator or the state agency notified. DON stated LPN-A did not	F 226	continue if necessary until 100% compliance is achieved. This information will be reported to the QAPI Committee. A vulnerable adult report was submitted and investigated by the DON on R147 with notice from OHFC that no further action was necessary. It is the intent of Glencoe Regional Health Services LTC facility to ensure that all allegations of abuse and neglect are reported to the administrator, OHFC, and the CEP immediately. The facility's Vulnerable Adult/Abuse Policy and reporting procedure has been reviewed and no changes are indicated at this time. On 9/24/14, the DON re-in serviced the full-time and part-time nursing staff on the facility's Vulnerable Adult/Abuse Policy/Procedure. The facility will report any event that is reportable under the State or Federal law per regulation to the administrator, OHFC, and the CEP immediately. Social Services will continue to review the Vulnerable Adult/Abuse Policy and reporting procedure annually and as needed with any changes in regulation. New employee orientation training includes the Vulnerable Adult Abuse and Neglect Policy. An annual Abuse & Neglect net learning module will be completed by all employees. The DON or designee will conduct Quality Assurance/Quality Improvement audits to	

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F 226	Continued From page 6 report this to her or anyone else at the facility that she was aware of, and per facility policy all staff is responsible for immediately reporting allegations of abuse either to the charge nurse, DON, administrator, social worker, or to the state agency. During interview on 9/17/14, at 4:17 p.m. registered nurse (RN)-A stated all allegations of abuse are reported to her, and LPN-A had not reported the allegation of verbal abuse by R147. RN-A stated according to facility policy, all staff is required to report allegations of abuse. LPN-A was unavailable to be interviewed during the survey. Housekeeper (H)-A was hired on 8/29/14. Upon review of H-A employee file there was no indication reference checks had been completed. During interview on 9/18/14, at approximately 10:00 a.m. human resource (HR)-A stated references checks should be completed for housekeeping personal, but they are not always documented. HR-A stated she was unable to provide any documentation H-A had reference checks completed.	F 226	ensure continued compliance regarding reporting allegations of abuse. Audits will be weekly for three months and/or until 100% compliance is achieved. The DON or designee will report the results of the audits to the QAPI Committee for review and follow-up action if needed. Submitted for Jon D. Braband, President & CEO	
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced	F 247		10/1/14

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F 247	Continued From page 7 by: Based on interview and document review, the facility failed to ensure 1 of 1 residents, (R104), who had a recent roommate change was notified prior to the roommate moving into the room. Findings include: R104's admission minimum data set (MDS) dated 8/15/14, indicated the resident had no cognitive impairment. During interview on 09/15/2014, at 4:36 p.m. R104 stated she had recently received a new roommate and had not been informed prior them moving in her room. Review of the current facility census indicated R104 received a new roommate on 9/13/14. During interview on 9/18/14, at 10:57 a.m. licensed social worker (LSW)-A stated the facility procedure for notifying residents of a new roommate was for social services to speak with the resident, and then write a note in the social services portion of the residents chart. LSW-A indicated R104's new roommate had came in on a weekend, when social services was not on duty, and there may not be any documentation to verify if R104 received notice of the roommate moving into the room. During interview on 9/15/14, at 11:07 a.m., LSW-A stated the nurse who admitted the resident was unavailable for interview, so the facility was not able to verify if R104 had been notified prior to receiving a roommate. LSW-A stated the facility did not have a written policy for notification of roommate changes and could not	F 247	A policy was created to notify all LTC residents of room/roommate changes. In-service education was provided to all charge nurses on 10/1/14 with regards to resident□s rights to receive advance notice of a change in room/roommate and on documentation requirements. When the LTC social worker is not available to notify resident of room/roommate changes it will be the LTC charge nurse's responsibility to follow facility's policy on notification and documentation requirements. The LTC social worker will audit room change notices and chart documentation of residents with new roommates to ensure that documentation of advance notice was given to the resident that a new roommate would be moving in. These audits will be conducted weekly for 4 weeks, then monthly for 2 months. Results of these audits will be brought to the LTC QAPI Committee for 3 months or until substantial compliance has been achieved and sustained as determined by the QAPI Committee. Submitted for Jon D. Braband, President & CEO	

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F 247	Continued From page 8 find evidence of documentation R104 was notified of the roommate change. R104's nursing progress notes were reviewed for the date of 9/13/14, the date her roommate entered the facility. There was no documentation R104 had been notified of the new roommate.	F 247		

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	245263	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/19/2014**

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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 FORM-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on September 19, 2014. At the time of this survey, Glencoe Regional Health Services C & NC was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care 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 Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/02/2014

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

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K 000	Continued From page 1 By eMail to: Marian.Whitney@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. Glencoe Regional Health Services C & NC was constructed in 1984, with one building addition constructed in 1995. Both buildings are one-story in height, have no basement, are fully fire sprinkler protected and were determined to be of Type I(332) construction. The facility has an automatic 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 is separated from both a hospital and a senior apartment building, by complying two-hour fire wall assemblies. The facility has a capacity of 110 beds and had a census of 99 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 011		9/20/14

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K 011	Continued From page 2 If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to properly maintain a required two-hour fire separation in accordance with NFPA 101 (2000), Chapter 19, Sections 19.1.1.4 and 19.1.2.1. This deficient practice could adversely affect the safety of 22 of 110 residents. FINDINGS INCLUDE: On 09/19/2014 at 11:05 AM, observation revealed building wiring penetrating the two-hour fire wall separating the nursing home from a senior apartment building. This penetration was located on the 300-Wing corridor, in the concealed space above the lay-in ceiling, directly above the fire door leading from the nursing home to the senior apartment building, and the interstitial space surrounding the wiring/cabling was not properly sealed with a listed fire-rated intumescent caulk or other approved method. This finding was verified with the facility building engineer at the time of discovery.	K 011	Tag On 09/20/2014 the penetration between the nursing home and senior apartment building was sealed by fire caulk. The Director of Maintenance will be responsible for the ongoing monitoring of the building fire barrier compliance. Submitted for Jon D. Braband, President & CEO	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
September 26, 2014

Mr. Jon Braband, Administrator
Glencoe Regional Health Services
1805 Hennepin Avenue North
Glencoe, Minnesota 55336

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5263023

Dear Mr. Braband:

The above facility was surveyed on September 15, 2014 through September 18, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule

is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00351	A. BUILDING: _____ B. WING _____	09/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENCOE REGIONAL HEALTH SERVICES	1805 HENNEPIN AVENUE NORTH GLENCOE, MN 55336

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement their Abuse Prohibition Plan and Prevention Policy for 1 of 1 resident (R147), who made an allegation of verbal abuse by staff. In addition, the facility failed to ensure 1 of 5 newly hired employees, housekeeper (H)-A, had reference checks completed. Findings include: Review of the facility's Vulnerable Adult/ Abuse Prohibition Plan and Prevention Policy dated	21995	It is the intent of Glencoe Regional Health Services LTC facility to ensure that all allegations of abuse and neglect are reported to the administrator, OHFC, and the CEP immediately. A vulnerable adult report was submitted and investigated by the Director of Nursing (DON) on R147 with notice from OHFC that no further action was necessary. The facility's Vulnerable Adult/Abuse	10/20/14

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21995	Continued From page 2 12/2013, instructed allegations of abuse were reported immediately to the administrator of the facility, and state agency. The policy also instructed all staff members will be screened as part of the pre-employment process and human resources will attempt to obtain information by checking a minimum of two references, including previous and/or current employers, and the results will be filed in their personnel files. R147's admission Minimum Data Set (MDS) dated 9/3/14, indicated R147 had no cognitive impairment. R147's care plan dated 9/16/14, indicated R147 required assistance for toileting and was incontinent of bowel and bladder. During interview on 9/17/14, at 2:03 p.m. R144 stated a staff member had come into her room during the night screaming and yelling at her roommate, R147. R144 stated staff screamed at R147 stating they had already been down to answer the call light five times. R147 had asked if they would check her brief because she thought she was wet. Staff stated to R147 if she did not stop turning the call light on and settle down they would get her up and bring her to the front desk. R144 reported the staff member stated to R147, "You left me a good old package," meaning a bowel movement. R144 was unable to identify the staff member who yelled at R147, but stated it was the night shift girl and the incident happened about a week ago. R144 stated she reported the incident to LPN-A the next morning, however, she had not heard anything and no one came and talked to her about the incident. During interview on 9/17/14, at 3:16 p.m. R147 stated she was verbally abused by a staff	21995	Policy and reporting procedure has been reviewed and no changes are indicated at this time. On 9/24/14, the DON re-in serviced the full-time and part-time nursing staff on the facility's Vulnerable Adult/Abuse Policy/Procedure. The facility will report any event that is reportable under the State or Federal law per regulation to the administrator, OHFC, and the CEP immediately. Social Services will continue to review the Vulnerable Adult/Abuse Policy and reporting procedure annually and as needed with any changes in regulation. New employee orientation training includes the Vulnerable Adult Abuse and Neglect Policy. An annual Abuse & Neglect net learning module will be completed by all employees. The DON or designee will conduct Quality Assurance/Quality Improvement audits to ensure continued compliance regarding reporting allegations of abuse. Audits will be weekly for three months and/or until 100% compliance is achieved. The DON or designee will report the results of the audits to the QAPI Committee for review and follow-up action if needed. Submitted for Jon D. Braband, President & CEO	

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21995	Continued From page 3	21995		

member about a week ago when she came into her room yelling at her and stated she used her call light too often and if she didn't stop they were going to make R147 come down by the nurses station. R147 stated she didn't want to go because she had diarrhea. R147 stated another staff member told her that staff member had used a very loud voice and it is not a way you should talk to someone. R147 stated the staff member was yelling at her so loud it woke her neighbor up (R144). R147 could not identify the staff member and stated she did not report it because she knew her roommate, R144, had told LPN-A about it the next morning. R147 stated no one at the facility spoke to her about the incident.

During interview on 9/17/14, at 4:00 p.m. the director of nursing (DON) stated she was not aware of R147's allegation of abuse, therefore the facility had no investigation, nor was the administrator or the state agency notified. DON stated LPN-A did not report this to her or anyone else at the facility that she was aware of, and per facility policy all staff is responsible for immediately reporting allegations of abuse either to the charge nurse, DON, social worker, or to the state agency.

During interview on 9/17/14, at 4:17 p.m. registered nurse (RN)-A stated all allegations of abuse are reported to her, and LPN-A had not reported the allegation of abuse by R147. RN-A stated according to facility policy, all staff is required to report allegations of abuse.

LPN-A was unavailable to be interviewed during the survey.

Housekeeper (H)-A was hired on 8/29/14. Upon review of H-A employee file there was no

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21995	Continued From page 4 indication reference checks had been completed. During interview on 9/18/14, at approximately 10:00 a.m. human resource (HR)-A stated references checks should be completed for housekeeping personal, but they are not always documented. HR-A stated she was unable to provide any documentation H-A had reference checks completed. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review the procedure for reporting to the state agency and the administrator in a timely manner with staff, and provide staff education. The quality assurance committee could randomly audit records to ensure compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21995		