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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: PZFT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00887

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245496**
2.STATE VENDOR OR MEDICAID NO.
(L2) **611042800**

3. NAME AND ADDRESS OF FACILITY
(L3) **MINNEOTA MANOR HEALTH CARE CENTER**
(L4) **700 NORTH MONROE STREET**
(L5) **MINNEOTA, MN** (L6) **56264**

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 12/02/2013 (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 **67** (L18)

13.Total Certified Beds **67** (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)
X 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: **A5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	67			
(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 :
Kathryn Series, HFE NEII 01/23/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 02/07/2014 (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
09/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/27/2013
(L33)

DETERMINATION APPROVAL

CCN: 24-5496

At the time of the August 1, 2013 standard survey the facility was not in substantial compliance with Federal Certification requirements. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D).

On September 17, 2013, a surveyor representing the Region V Office of the Centers for Medicare and Medicaid Services (CMS) completed a Life Safety Code (LSC) Federal Monitoring Survey (FMS). The FMS revealed that the facility continued to not be in substantial compliance. The most serious deficiencies in the facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), whereby corrections were required.

As a result of the standard survey and the Federal Monitoring survey, CMS imposed the following enforcement remedy:

> Mandatory denial of payment for new Medicare and Medicaid admissions effective November 1, 2013 (42 CFR 488.417(b))

The facility was subject to a loss of NATCEP if the facility were to go into denial of payment.

On September 18, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of the facility's plan of correction and on December 2, 2013 the Minnesota Department of Public Safety completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 1, 2013 and an FMS completed on September 17, 2013. We presumed, based on the facility's plan of correction, that the facility had corrected these deficiencies as of November 5, 2013. Based on the PCR, we have determined that the facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 1, 2013 and FMS completed on September 17, 2013, effective November 5, 2013.

As a result of the PCR findings, this Department recommended the following to the CMS RO:

> Mandatory denial of payment for new Medicare and Medicaid admissions effective November 1, 2013 is rescinded.

The facility is no longer subject to a loss of NATCEP

The facility's request for a continuing waiver involving the deficiency cited under K67 at the time of the September 17, 2013 Federal Monitoring Survey (FMS), has been approved.

Effective November 5, 2013, the facility is certified for 67 skilled nursing facility beds. Refer to the CMS 2567B

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5496 February 7, 2014

Ms. Kathy Johnson, Administrator
Minneota Manor Health Care Center
700 North Monroe Street
Minneota, Minnesota 56264

Dear Ms. Johnson:

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 November 5, 2013, the above facility is certified for:

67 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 67 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,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900, St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

January 23, 2014

Ms. Kathy Johnson, Administrator
Minneota Manor Health Care Center
700 North Monroe Street
Minneota, Minnesota 56264

RE: Project Number S5496024, F5496023

Dear Ms. Johnson:

On August 19, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 1, 2013 that included an investigation of complaint number . This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

In addition, on September 17, 2013, A surveyor representing the Region V Office of the Centers for Medicare and Medicaid Services (CMS) completed a Life Safety Code (LSC) Federal Monitoring Survey (FMS) of your facility. As you were informed during the exit conference the FMS revealed that your facility continues to not be in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), whereby corrections were required.

On October 21, 2013, CMS forwarded the results of the FMS to you and informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 1, 2013 (42 CFR 488.417(b))

On September 18, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 2, 2013 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 August 1, 2013 and an FMS completed on September 17, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 5, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 1, 2013 and FMS completed on September 17, 2013, effective November 5, 2013.

As a result of the PCR findings, this Department recommended to the Region V Office of CMS the following actions related to the remedies in their letter of October 21, 2013. CMS concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 1, 2013 is rescinded. (42 CFR 488.417(b))

Your request for a continuing waiver involving the deficiency cited under K67 at the time of the September 17, 2013 Federal Monitoring Survey (FMS), has been approved.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5496r13.rtf

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
245496	A. Building B. Wing	9/18/2013

Name of Facility	Street Address, City, State, Zip Code
MINNEOTA MANOR HEALTH CARE CENTER	700 NORTH MONROE STREET MINNEOTA, MN 56264

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 **08/30/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **08/30/2013**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **08/30/2013**
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** MM/KS	**Date:** 01/23/2014	**Signature of Surveyor:** 03048	**Date:** 09/18/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 8/1/2013		**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
245496	01 - MAIN BUILDING 01	12/2/2013

Name of Facility	Street Address, City, State, Zip Code
MINNEOTA MANOR HEALTH CARE CENTER	700 NORTH MONROE STREET MINNEOTA, MN 56264

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 Reg. # NFPA 101 LSC K0076	08/05/2013	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 MM/PS	Date: 01/23/2014	Signature of Surveyor: 22373	Date: 12/02/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 7/30/2013		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

FMS

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245496	A. Building 01 - MAIN BUILDING 01 B. Wing	12/2/2013

Name of Facility	Street Address, City, State, Zip Code
MINNEOTA MANOR HEALTH CARE CENTER	700 NORTH MONROE STREET MINNEOTA, MN 56264

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 Reg. # NFPA 101 LSC K0066	10/28/2013	ID Prefix Reg. # NFPA 101 LSC K0069	11/05/2013	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 MM/PS	Date: 01/23/2014	Signature of Surveyor: 22373	Date: 12/02/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 9/17/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

FAX to:

Number of Pages:

CCN: 245496

Name: Minnesota Manor Health Care Center

City, State: Minneota, MN

3 Month Date: 11/5/13

6 Month Date: 2/5/14

FMS Survey Date: 9/17/13

Fed Surveyor:

Contr Surveyor: 32812

S/S	Tag	POC Date or Temporary Waiver ("TW") Date or Waiver ("W")	
D	K66	POC 10/28/13	Annotate 2567
F	K67	AW	Waiver form
E	K69	POC 11/5/13	AEM: W, TW
			ASPEN: IDR
			ASPEN: Update citations
			ASPEN: Enter POC dates
			Print Revised 2567
			Letter; in H; in AEM; lock
			Tell facility POC is OK
			Ask State to revisit
			AEM note

Approved: (YES) NO By: S. Peliaski Date: 11/5/13

RO V LSC Annual Waiver Checklist

Facility: Minneota Manor Health Care Center CCN: 245496

Date of Survey: 09/17/2013 K Tag: K67

Summary of Deficiency:

Corridor plenum

Was this deficiency previously waived? No Date: Click here to enter a date.

SA Recommendation: No Recommendation

Evidence that lack of correction will not adversely affect resident health and safety:

Fully sprinklered facility.

Evidence that corrective action would pose an unreasonable hardship on the facility:

Financial hardship to correct.

RO Decision: Approve Date: 11/05/2013

Comments:

Click here to enter text.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245496	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/17/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEOTA MANOR HEALTH CARE CENTER	**700 NORTH MONROE STREET** **MINNEOTA, MN 56264**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 42 CFR 483.70(a) K3 BUILDING: 0101 K6 PLAN APPROVAL: 1972 and 1995 K7 SURVEY UNDER: 2000 EXISTING K8 SNF/NF Type of Structure: One story, Type II (111), 1972, protected, noncombustible concrete and steel framed construction. The facility has four smoke compartments and a complete automatic (wet) sprinkler system. The dry system is limited to the exterior heads at the front entrance. A Comparative Federal Monitoring Survey was conducted on 9/17/2013, following a State Agency Survey on 7/30/2013, in accordance with 42 Code of Federal Regulations, Part 483: Requirements for Long Term Care Facilities. During this Comparative Federal Monitoring Survey, Minneota Manor Health Care Center was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire).	K 000		
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such	K 066		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathy Johnson — TITLE: Administrator — (X6) DATE: 10/31/2013

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
	245496	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/17/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEOTA MANOR HEALTH CARE CENTER	**700 NORTH MONROE STREET MINNEOTA, MN 56264**

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K 066	Continued From page 1 area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide metal containers with self-closing devices into which ashtrays can be emptied. The deficient practice affected one of four smoke compartments, four staff and two residents. The facility has the capacity for 67 beds with a census of 62 the day of survey. Findings Include: Observation on 9/17/13 from 3:00 p.m. to 3:20 p.m. revealed the designated outdoor facility staff and facility resident smoking areas near the 400 Wing and adjacent courtyard were not equipped with metal containers with a self-closing covers into which ashtrays could be emptied and to permit smoking materials to be completely extinguished prior to disposal with other	K 066	Metal containers with self-closing cover devices were placed in 400 wing and adjacent courtyard which are the designated smoking areas for staff and residents. Staff and residents are required to smoke in the designated smoking areas in which the metal self closing containers have been placed. These self-closing metal containers will remain in the designated smoking areas at all times Housekeeping staff will clean smoke areas daily and all ashtrays will be disposed of in the self closing metal containers. The safety director will make a visual audit weekly x 1 month then monthly x 12 months to ensure these containers remain in the smoking areas. These audits will be reported at monthly QA meetings.	10-28-13 9-17-13 ongoing ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245496	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/17/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEOTA MANOR HEALTH CARE CENTER	**700 NORTH MONROE STREET MINNEOTA, MN 56264**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 066	Continued From page 2 combustible trash. Interview on 9/17/13 at 3:20 p.m. with the facility maintenance supervisor revealed the facility was not aware of the requirement to provide a metal container with a self-closing cover in smoking areas. The census of 62 was verified by the Administrator on 9/17/13. The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor during the exit interview on 9/17/13. Actual NFPA Standard: NFPA 101 19.7.4 (3), (4). Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted.	K 066		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain a balanced engineered return air supply system without using the corridor as a return air plenum. The deficient practice affected four of four smoke compartments, staff, and all residents. The facility has the capacity for 67 beds with a census of 62 the day of survey.	K 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245496	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/17/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEOTA MANOR HEALTH CARE CENTER	**700 NORTH MONROE STREET MINNEOTA, MN 56264**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 067	Continued From page 3 Observation on 9/17/13 at 3:30 p.m. revealed the facility was using the corridor area below the ceiling as a return air plenum throughout the building. Only supply registers were observed inside resident rooms, storage rooms, and office areas. The vent inside of each resident room bathroom did not return air manually or automatically when the supply registers were supplying air into the resident rooms. Return registers were observed below the ceiling in the corridor pulling air from these rooms through the corridor space below the ceiling. The facility was unable to provide evidence of a balanced engineered HVAC system without using the exit corridor space as a return air plenum. Interview with the Administrator on 9/17/13 at 3:30 p.m. revealed the facility was not aware of the requirement to prohibit the use of egress corridors as return air plenums. The census of 62 was verified by the Administrator on 9/17/13. The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor on 9/17/13 during the exit conference. Actual NFPA Standard: NFPA 90A section 2-3.11.1* Egress corridors in health care, detention and correctional, and residential occupancies shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas. An air transfer opening(s) shall not be permitted in walls or in doors separating egress corridors from adjoining areas. Exception No. 1: Toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces opening directly onto the egress corridor.	K 067	An annual waiver is requested for the ventilation system and is attached. Most rooms affected by this have the doors open into the hallway the majority of the time so that air is able to return through the corridor.	10-31-13 10-31-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245496	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/17/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEOTA MANOR HEALTH CARE CENTER	**700 NORTH MONROE STREET MINNEOTA, MN 56264**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 067	Continued From page 4 Exception No. 2: Where door clearances do not exceed those specified for fire doors in NFPA 80, Standard for Fire Doors and Fire Windows, air transfer caused by pressure differentials shall be permitted. Exception No. 3: Use of egress corridors as part of an engineered smoke-control system. Exception No. 4: In detention and correctional occupancies with corridor separations of open construction (e.g., grating doors or grating partitions).	K 067		
K 069 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure the kitchen's fire suppression system was connected to the fire alarm system. The deficient practice affected one of four smoke compartments (including the Dining Room), four staff, and fifteen residents. The facility has the capacity for 67 beds with a census of 62 the day of the survey. Findings include: Record review on 9/17/13 at 2:05 p.m. of the facility's fire suppression system inspection reports dated 04/16/13 and 10/19/12 revealed the fire suppression system serving the cooking equipment in the kitchen was not connected to the fire alarm system. Interview on 9/17/13 at 2:05 p.m. with the Maintenance Supervisor revealed the facility was not aware the suppression system was not	K 069		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245496	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/17/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEOTA MANOR HEALTH CARE CENTER	**700 NORTH MONROE STREET MINNEOTA, MN 56264**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 069	Continued From page 5 connected to the fire alarm system. The census of 62 was verified by the Administrator on 9/17/13. The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor during the exit interview on 9/17/13. Actual NFPA Standard: NFPA 72, 3-8.3.2.5.1. The operation of an automatic fire suppression system installed within the protected premises shall cause an alarm signal at the protected premises fire alarm control unit. Actual NFPA Standard: NFPA 17A, 5-3.1.1. At least semiannually, maintenance shall be conducted in accordance with the manufacturer's listed installation and maintenance manual. Actual NFPA Standard: NFPA 17A, 5-3.1.1 (g). The maintenance report, with recommendations, if any, shall be filed with the owner or with the designated party responsible for the system. Actual NFPA Standard: NFPA 17A, 5-3.1.1 (h). Each wet chemical system shall have a tag or label securely attached, indicating the month and year the maintenance is performed and identifying the person performing the service. Only the current tag or label shall remain in place.	K 069	The fire suppression system serving the cooking equipment in the kitchen was connected to the fire alarm system. The fire suppression system was installed and tested to ensure it operated and alarmed per the standard. The alarm system will be inspected at least semiannually per the standard by our contracted alarm testing company. The maintenance director will be responsible for scheduling the semiannual inspections.	10-30-13 11-5-13 11-5-13 ongoing ongoing

Thursday, October 31, 2013

Stephen Pelinski, Branch Manager
Centers for Medicare and Medicaid Services
Division of Survey and Certification
233 North Michigan Avenue, Suite 600
Chicago, IL 60601-5519

Dear Mr. Pelinski,

I am writing to request an annual waiver for the life safety code deficiency K067 that we were issued on our federal monitoring survey on September 17, 2013. I am requesting the annual waiver due to financial hardship in order to correct this deficiency.

Attached is the price quote I received from Bisbee Plumbing and Heating. The cost would be in the range of $90,000 - 100,000. This would create a financial hardship for our facility to replace at this time.

Thank you for your consideration.

Sincerely,
Kathy Johnson
Kathy Johnson
Minneota Manor Health Care Center
(507)872-5302
kathy@minmanor.com

Bisbee Plumbing & Heating

Complete Commercial Mechanical Contracting and Metal Fabricating

604 North Hwy. 59, P.O. Box 3
Marshall, Minnesota 56258

PHONE: 507-537-0596
FAX: 507-537-1431

October 29, 2013

Mrs. Johnson
Minneota Manor
700 North Monroe St.
Minneota, Minnesota 56264

RE: Return Air Ducting

Mrs. Johnson,

Bisbee Plumbing & Heating did research into the Minneota Manor return air system for the South Wing, North Wing and a couple of rooms in West Wing. Looking at these systems, in order to install return air duct out of every room walls will need to be busted through into hallways and ceilings will have to be taken down in rooms (partially) and all of the hallways ceilings in order for us to install return air duct back to the rooftop air handling units. Also required would be sprinkler contractor to remove some of the sprinkler lines that are above the ceilings and in the way. Because of going from room to hallway there may be fire dampers or fire/smoke damper required for fire protection.

With this being said Bisbee's is estimating that the cost to do this work could be in the range of $ 90,000 to $ 100,000.00 depending on what will be required.

Sincerely,
Bisbee Plumbing & Heating

Jack Mead

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PZFT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00887

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245496**
2.STATE VENDOR OR MEDICAID NO.
(L2) **611042800**

3. NAME AND ADDRESS OF FACILITY
(L3) **MINNEOTA MANOR HEALTH CARE CENTER**
(L4) **700 NORTH MONROE STREET**
(L5) **MINNEOTA, MN** (L6) **56264**

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 **08/01/2013** (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 **67** (L18)

13.Total Certified Beds **67** (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
	67			
(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 :
Wendy Buckholz, HFE NEII 09/05/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/27/2013 (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
09/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/27/2013
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5496

At the time of the August 1, 2013 standard survey the facility was not in substantial compliance with Federal participation requirements. 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

Certified Mail # 7011 2000 0002 5143 5261

August 19, 2013

Ms. Kathy Johnson, Administrator
Minneota Manor Health Care Center
700 North Monroe Street
Minneota, Minnesota 56264

RE: Project Number S5496024

Dear Ms. Johnson:

On August 1, 2013, 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 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. 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>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:

Kathryn Serie
Minnesota Department of Health
Mankato Place
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001

Telephone: (507) 537-7158

Fax: (507) 344-2716

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 September 10, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

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

If an acceptable PoC 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 PoC 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 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 November 1, 2013 (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 February 1, 2014 (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 a PoC 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.

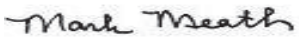
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

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

Sincerely,



Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5496s13.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245496	A. BUILDING _____ B. WING _____	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEOTA MANOR HEALTH CARE CENTER	700 NORTH MONROE STREET MINNEOTA, MN 56264

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. 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 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 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 follow the plan of care for 1 of 3 residents (R52) in the sample reviewed for non-pressure related skin issues. Findings include: Bruises observed on R52's right hand and left wrist/hand had not been monitored as directed by the plan of care. During review of the (undated) care plan for R52, a problem area dated 5/21/13, identified: "BLOOD THINNER - Resident at risk for injury" related to aspirin use and a diagnosis of atrial fibrillation, (a note on the care plan indicated the aspirin had been on hold as of	F 282	approved 9/4/2013 KMS RECEIVED SEP 0 3 2013 Minnesota Dept of Health Mankato	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathy Johnson — TITLE: Administrator — (X6) DATE: 8-30-13

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
	245496	A. BUILDING _____ B. WING _____	08/01/2013

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F 282	Continued From page 1 5/21/13). Approaches included, "Report indicators of excessive bleeding or bleeding to MD including--coffee ground emesis, bruising, petechiae, dark colored or bloody stools, avoid straight edge razors." The plan of care also identified a problem area dated 7/9/12, of "bruising potential" related to methotrexate injections. Approaches included, "Report bruising/injury to nurse. Investigate and monitor as needed." During an observation on 7/29/13 at 7:26 p.m., R52 was observed to have a large purplish bruise located on the top aspect of each hand, and also a large purplish bruise on top of the left wrist. R52 was interviewed at that time regarding the bruises. R52 was unable to remember how she may have obtained the bruises but stated, "I usually get them (the bruises) from bumping something". She stated that she bruises, "all the time" due to the use of blood thinner medications. During record review, it was noted that documentation related to the bruising of R52's hands and left wrist was lacking. No mention of bruising was evident to indicate that staff had monitored them in relation to the potential side effects of R52's current medication regimen; methotrexate injections. During interview on 8/1/13 at 12:12 p.m., registered nurse (RN)-A reported being unaware of the bruising to R52's hands. RN-A then visualized R52's hands with the surveyor present and confirmed the bruising should have been monitored according to the plan of care. Following interview with RN-A, "A Skin Integrity Events" form was reviewed for R52. The form	F 282	F 282 On August 1, 2013 when case manager became aware of the bruises and issue a monitoring task was placed in the EMAR of R52 to monitor bruised area until healed. Care plan for R52 was reviewed and changes were made to care plan in the area of bruising risk as follows. Nursing assistants and Nurses were reeducated on the need to report all skin issues that are new to them. Nurses and TMAs were then instructed to check the record when a bruise is reported to ensure that our process if followed through on. DON and Nurse Managers will review and audit 3 random residents monthly to check for bruising and determine that appropriate paperwork has been completed. These audits will occur monthly x 3 then quarterly for 9 months. Plan will be reviewed at QA meeting in September, 2013. **Compliance with plan and all re-education completed by August 30, 2013** RECEIVED SEP 0 3 2013 Minnesota Dept of Health Mankato	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245496	A. BUILDING _____ B. WING _____	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEOTA MANOR HEALTH CARE CENTER	700 NORTH MONROE STREET MINNEOTA, MN 56264

(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 282	Continued From page 2 dated and timed as 8/1/13, 1:15 p.m., included measurements of the bruises: (1) size of bruise on right hand: 4.5 cm [centimeters] x 3 cm laterally; 2.5 cm x 3 cm medially; (2) right wrist bruise: 2 cm x 2 cm laterally; 2 cm x 1.5 cm medially; and (3) left hand bruise: 4 cm x 6 cm; left wrist: 3 cm x 5 cm.	F 282		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by:	F 329		

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F 329	Continued From page 3 Based on interview and document review, the facility failed to adequately monitor for side effects related to bruising for 1 of 5 residents (R52) reviewed for unnecessary medications. Findings include: R52 was observed on 7/29/13, at 7:26 p.m. The resident had a large purplish bruise on the top aspect oft the right and left hands, and a large purplish bruise on the top of her left wrist. R52 was interviewed at that time and said she was unable to remember how she may have sustained the bruises. R52 stated, "I usually get them (the bruises) from bumping something," and that she bruised "all the time" due to the use of blood thinner medication. During an observation on 7/31/13 at 9:28 a.m., R52 was observed wheeling herself into her bedroom independently. The bruises were still present on the top aspects of both hands, and the top of her left wrist and appeared to be at various stages of healing. The resident again stated she bruised easily because of blood thinning medications. R52 stated, "It doesn't take much" to sustain bruising. R52's record was reviewed. R52 had been admitted to the facility in 2011 with diagnoses including atrial fibrillation, rheumatoid arthritis and Parkinson's disease. The physician's orders revealed R52 received a weekly injection of methotrexate sodium for rheumatoid arthritis. During review of the (undated) care plan for R52, a problem area dated 5/21/13, identified: "BLOOD THINNER - Resident at risk for injury" related to aspirin use and a diagnosis of atrial fibrillation, (a	F 329	F 329 On August 1, 2013 when case manager became aware of the bruises and issue a monitoring task was placed in the EMAR of R52 to monitor bruised area until healed. Care plan for R52 was reviewed and changes were made to care plan in the area of bruising risk as follows. Upon receipt of the 2567 writer reviewed side effects of Methotrexate and bruising is not listed as side effect of the medication. The bruising may be a result of the on-going blood work required to monitor for potential organ damage related to this medication. Writer spoke with pharmacist and verified that Methotrexate does not cause bruising. One side effect is thrombocytopenia, but resident has her platelet count checked every other month. Her most recent was done on July 12, 2013 with a result of 151 (normal range: 140-420). The resident had already been taken off aspirin on May 21, 2013 and Coumadin on January 19, 2013. Writer spoke with resident's primary MD about the concern. Primary MD completed a risk/benefit review and continues to feel that the Methotrexate is required for the resident's management of rheumatoid arthritis. Bruising was reviewed at QA and the facility will review residents' medication regime for unnecessary drugs with quarterly assessments. The MDS nurse's will be reeducated by August 30, 2013. This plan will be reviewed at QA in September, 2013. The facility will be compliant with plan by August 30, 2013. Compliance with plan and all re-education completed by August 30, 2013	

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F 329	Continued From page 4 note on the care plan indicated the aspirin had been on hold as of 5/21/13). Approaches included, "Report indicators of excessive bleeding or bleeding to MD including--coffee ground emesis, bruising, petechiae, dark colored or bloody stools, avoid straight edge razors." The plan of care also identified a problem area dated 7/9/12, of "bruising potential" related to weekly methotrexate injections. Approaches included, "Report bruising/injury to nurse. Investigate and monitor as needed." During record review, it was noted that documentation related to the bruising of R52's hands and left wrist was lacking. No mention of bruising was evident to indicate that staff had monitored them in relation to the potential side effects of R52's current medication regimen; methotrexate injections. During interview on 8/1/13 at 12:12 p.m., registered nurse (RN)-A reported being unaware of the bruising to R52's hands. RN-A then visualized R52's hands with the surveyor present and confirmed the bruising should have been monitored. Following interview with RN-A, "A Skin Integrity Events" form was reviewed for R52. The form dated and timed as 8/1/13, 1:15 p.m., included measurements of the bruises: (1) size of bruise on right hand: 4.5 cm [centimeters] x 3 cm laterally; 2.5 cm x 3 cm medially; (2) right wrist bruise: 2 cm x 2 cm laterally; 2 cm x 1.5 cm medially; and (3) left hand bruise: 4 cm x 6 cm; left wrist: 3 cm x 5 cm.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION	F 356		

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F 356	Continued From page 5 The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to post the required licensed nurse daily staffing data. This had the potential to affect each of the 63 current residents and/or their families and any other members of	F 356	F 356 On August 1, 2013 writer was made aware of the error to the posted nursing hours. On August 2, 2013 the form was corrected to separate out the RN and LPN hours per the requirement. Policy was reviewed and amended to include the need to separate the RN and LPN hours. The policy change was reviewed at Quality Assurance meeting on August 7th. Scheduling coordinator and nursing staff was educated on the policy change August 22, 2013 at the nursing meeting and in the minutes sent out to staff who were unable to attend with the payroll dispensed August 30, 2013. Audits will be completed monthly for six months then quarterly for 1 year by Director of Nursing or designated staff to ensure the correction has been made and continues. Plan was reviewed at QA meeting on August 7, 2013. **Compliance with plan and all re-education completed by August 30, 2013**	

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F 356	Continued From page 6 the public who wished to view the data. Findings include: During the initial facility tour on 7/29/13, and during additional observations made daily on 7/30/13, 7/31/13 and 8/1/13, the posted Census/Staffing Layout form did not include either the registered nurse (RN) hours nor the licensed practical nurse (LPN) hours worked. The director of nursing on 8/1/13, at 2:40 p.m. verified that the hours posted under the heading Nursing, included combined RN and LPN hours rather than posting each separately.	F 356		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245496	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/30/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEOTA MANOR HEALTH CARE CENTER	**700 NORTH MONROE STREET MINNEOTA, MN 56264**

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K 000	INITIAL COMMENTS	K 000		

Dc: 09.10.2013

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 July 30, 2013. At the time of this survey, Minneota Manor Health Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.

Exit: 08.01.2013

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

RECEIVED
SEP 3 2013
MN DEPT OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

POC o/k 9-5-13
Last DATE 8-5-13 ~

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kamy Johnson	Administrator	8-30-13

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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MINNEOTA MANOR HEALTH CARE CENTER	**700 NORTH MONROE STREET** **MINNEOTA, MN 56264**

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K 000	Continued From page 1 By eMail to: Barbara.Lundberg@state.mn.us, and 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. Minneota Manor Health Care Center was constructed as follows: The original building was constructed in 1972, is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 1995 building addition is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. The nursing home is separated from an assisted living facility by 2-hour fire walls, with opening protectives consisting of labeled, self-closing, positive latching, 90-minute fire-rated door assemblies. 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 67 beds and had a census of 62 at	K 000		

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K 000	Continued From page 2 time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation, the facility was storing medical gas cylinders in a manner not in conformance with NFPA 99 (1999 edition) Chapter 4, Section 4-3.1.1.1. This deficient practice could adversely affect residents, staff or visitors in the vicinity of the Oxygen Storage Room. FINDINGS INCLUDE: On 7/30/2013 at 12:15 PM, observation revealed three (3) empty oxygen cylinders stored inside of the Main Oxygen Storage Room. These cylinders were stored on the floor surface, in an upright position, and were not secured and	K 076		

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K 076	Continued From page 3 located to prevent tipping/falling. This free-standing storage arrangement was not in conformance with NFPA 99 (1999), Chapter 4, Section 4-3.1.1.1 and Chapter 8, Section 8-3.1.1. This finding was confirmed with the chief building engineer at the time of discovery.	K 076	An extra oxygen storage rack was requested from our oxygen supply company and placed in the med room for extra empty containers to be placed in. A sign was place in the med room by the racks to remind all staff to place the containers in the rack. The Safety Manager will complete monthly audits x 3 months, then quarterly for one year to make sure containers are stored in the racks. Audits will be discussed at QA safety meetings. The Safety Manager will monitor the plan of correction.	7-30-13 8-5-13 ongoing

Minnesota Department of Health

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	00887	A. BUILDING: _____ B. WING _____	08/01/2013

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On July 29th, 30th, 31st and August 1st, 2013 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of	2 000	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	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathy Johnson — TITLE: Administrator — (X6) DATE: 8-30-13

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 5261

August 19, 2013

Ms. Kathy Johnson, Administrator
Minneota Manor Health Care Center
700 North Monroe Street
Minneota, Minnesota 56264

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5496024

Dear Ms. Johnson:

The above facility was surveyed on July 29, 2013 through August 1, 2013 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.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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.

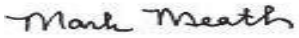
When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, Mankato Place 12 Civic Center Plaza Suite 2105 Mankato Minnesota 56001. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Kathryn Serie at (507) 537-7158.

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

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

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

Sincerely,



Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEOTA MANOR HEALTH CARE CENTER	700 NORTH MONROE STREET MINNEOTA, MN 56264

(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	Continued From page 1 Compliance Monitoring, Licensing and Certification Program; 12 Civic Center Plaza, Suite 2105, Mankato, Minnesota 56001	2 000	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 which 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.	
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00887	A. BUILDING: _____ B. WING _____	08/01/2013

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2 565	Continued From page 2 must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the plan of care for 1 of 3 residents (R52) in the sample reviewed for non-pressure related skin issues. Findings include: Bruises observed on R52's right hand and left wrist/hand had not been monitored as directed by the plan of care. During review of the (undated) care plan for R52, a problem area dated 5/21/13, identified: "BLOOD THINNER - Resident at risk for injury" related to aspirin use and a diagnosis of atrial fibrillation, (a note on the care plan indicated the aspirin had been on hold as of 5/21/13). Approaches included, "Report indicators of excessive bleeding or bleeding to MD including--coffee ground emesis, bruising, petechiae, dark colored or bloody stools, avoid straight edge razors." The plan of care also identified a problem area dated 7/9/12, of "bruising potential" related to weekly methotrexate injections. Approaches included, "Report bruising/injury to nurse. Investigate and monitor as needed." During an observation on 7/29/13 at 7:26 p.m., R52 was observed to have a large purplish bruise located on the top aspect of each hand, and also a large purplish bruise on top of the left wrist. R52 was interviewed at that time regarding the bruises. R52 was unable to remember how she	2 565		

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2 565	Continued From page 3 may have obtained the bruises but stated, "I usually get them (the bruises) from bumping something". She stated that she bruises, "all the time" due to the use of blood thinner medications. During record review, it was noted that documentation related to the bruising of R52's hands and left wrist was lacking. No mention of bruising was evident to indicate that staff had monitored them in relation to the potential side effects of R52's current medication regimen; methotrexate injections. During interview on 8/1/13 at 12:12 p.m., registered nurse (RN)-A reported being unaware of the bruising to R52's hands. RN-A then visualized R52's hands with the surveyor present and confirmed the bruising should have been monitored according to the plan of care. Following interview with RN-A, "A Skin Integrity Events" form was reviewed for R52. The form dated and timed as 8/1/13, 1:15 p.m., included measurements of the bruises: (1) size of bruise on right hand: 4.5 cm [centimeters] x 3 cm laterally; 2.5 cm x 3 cm medially; (2) right wrist bruise: 2 cm x 2 cm laterally; 2 cm x 1.5 cm medially; and (3) left hand bruise: 4 cm x 6 cm; left wrist: 3 cm x 5 cm. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		

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21535	Continued From page 4	21535		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to adequately monitor for side effects related to bruising for 1 of 5 residents (R52) reviewed for unnecessary medications. Findings include: R52 was observed on 7/29/13, at 7:26 p.m. The resident had a large purplish bruise on the top aspect oft the right and left hands, and a large	21535		

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21535	Continued From page 5	21535		

purplish bruise on the top of her left wrist. R52 was interviewed at that time and said she was unable to remember how she may have sustained the bruises. R52 stated, "I usually get them (the bruises) from bumping something," and that she bruised "all the time" due to the use of blood thinner medication.

During an observation on 7/31/13 at 9:28 a.m., R52 was observed wheeling herself into her bedroom independently. The bruises were still present on the top aspects of both hands, and the top of her left wrist and appeared to be at various stages of healing. The resident again stated she bruised easily because of blood thinning medications. R52 stated, "It doesn't take much" to sustain bruising.

R52's record was reviewed. R52 had been admitted to the facility in 2011 with diagnoses including atrial fibrillation, rheumatoid arthritis and Parkinson's disease. The physician's orders revealed R52 received a weekly injection of methotrexate sodium for rheumatoid arthritis.

During review of the (undated) care plan for R52, a problem area dated 5/21/13, identified: "BLOOD THINNER - Resident at risk for injury" related to aspirin use and a diagnosis of atrial fibrillation, (a note on the care plan indicated the aspirin had been on hold as of 5/21/13). Approaches included, "Report indicators of excessive bleeding or bleeding to MD including--coffee ground emesis, bruising, petechiae, dark colored or bloody stools, avoid straight edge razors." The plan of care also identified a problem area dated 7/9/12, of "bruising potential" related to weekly methotrexate injections. Approaches included, "Report bruising/injury to nurse. Investigate and monitor as needed."

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21535	Continued From page 6 During record review, it was noted that documentation related to the bruising of R52's hands and left wrist was lacking. No mention of bruising was evident to indicate that staff had monitored them in relation to the potential side effects of R52's current medication regimen; methotrexate injections. During interview on 8/1/13 at 12:12 p.m., registered nurse (RN)-A reported being unaware of the bruising to R52's hands. RN-A then visualized R52's hands with the surveyor present and confirmed the bruising should have been monitored. Following interview with RN-A, "A Skin Integrity Events" form was reviewed for R52. The form dated and timed as 8/1/13, 1:15 p.m., included measurements of the bruises: (1) size of bruise on right hand: 4.5 cm [centimeters] x 3 cm laterally; 2.5 cm x 3 cm medially; (2) right wrist bruise: 2 cm x 2 cm laterally; 2 cm x 1.5 cm medially; and (3) left hand bruise: 4 cm x 6 cm; left wrist: 3 cm x 5 cm. SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the need for medication monitoring with the licensed staff. She could randomly audit resident medication orders to ensure that medications were utilized in accordance with accepted standards, and to ensure medications were monitored for potential adverse effects. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		