DEPARTMENT OF HEALTH AN	D HUMA	N SERVICES			CENTERS FOR MED	DICARE & MEDIC	AID SERVICES
	MEDICA	ARE/MEDICAI	D CERTIFIC	CATION A	AND TRANSMITTAL	П	D: QFKO
	PART I -	TO BE COMPL	LETED BY T	THE STAT	TE SURVEY AGENCY	F	acility ID: 00576
1. MEDICARE/MEDICAID PROVIDER NO.(L1) 245548		3. NAME AND AD (L3) TUFF MEM				 TYPE OF ACTION Initial 	N: <u>7</u> (L8) 2. Recertification
2. STATE VENDOR OR MEDICAID NO. (L2) 230743000		(L4) 505 EAST 4 (L5) HILLS, MN	TH STREET		(L6) 56138	 Termination Validation On-Site Visit 	 CHOW Complaint Other
5. EFFECTIVE DATE CHANGE OF OWNE (L9)	ERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEG 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	 8. Full Survey After 	
	6 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/IID		FISCAL YEAR ENDIN	IG DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30	
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:			
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requireme	nts:
To (b):		Program Re Compliance			2. Technical Personnel	6. Scope of Ser	vices Limit
					3. 24 Hour RN	7. Medical Dire	
12.Total Facility Beds 5	(L18)	1. Ad	cceptable POC		4. 7-Day RN (Rural SN		n Size
-	50 (L17)	B. Not in Compl	liance with Progra	am	5. Life Safety Code	9. Beds/Room	
			and/or Applied V		* Code: A*	(L12)	
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
50							
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMARKS	(IF APPLICA	BLE SHOW LTC CA	NCELLATION	DATE).			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
Joseph Garvey, HFE NE	П	0	8/10/2016		Kamala Fiske-Downing, Health I	Program Representative	9/1/2016
				(L19)			9/1/2010 (L20)
PART II	- TO BE	COMPLETED E	BY HCFA RE	EGIONAI	L OFFICE OR SINGLE S	TATE AGENCY	
19. DETERMINATION OF ELIGIBILITY			PLIANCE WITH	H CIVIL	21. 1. Statement of Finan		
1. Facility is Eligible to Particip	ate	RIGH	ITS ACT:		 Ownership/Contro Both of the Above 	l Interest Disclosure Stmt (:	HCFA-1513)
2. Facility is not Eligible							
	(L21)						
22. ORIGINAL DATE 23.	LTC AGREEN	MENT 24	. LTC AGREEN	/IENT	26. TERMINATION ACTION:	(1	L30)
OF PARTICIPATION	BEGINNINC	5 DATE	ENDING DA	ГЕ	VOLUNTARY 00	INVOLUN	TARY
03/01/1991					01-Merger, Closure		feet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse		feet Agreement
25. LTC EXTENSION DATE: 27.	ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	n <u>OTHER</u>	
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal		r Status Change
(L27)	D Descoind St	spension Date:	(L44)			00-Active	
	D. Resellid St	ispension Date.	(L45)				
28. TERMINATION DATE:	20	. INTERMEDIARY/			30. REMARKS		
26. TERMINATION DATE.	29		CARRIER NO.		JU. REMARKS		
/7	20)	03001		(1.21)			
(L	.28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE			
(L	.32)			(L33)	DETERMINATION APPE	ROVAL	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

REVISED LETTER

CMS Certification Number (CCN): 245548

September 1, 2016

Mr. Alex Dysthe, Administrator Tuff Memorial Home 505 East 4th Street Hills, MN 56138

Please note this letter has a revised certification effective date.

Dear Mr. Dysthe:

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 August 5, 2016 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 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.

Tuff Memorial Home August 11, 2016 Page 2 Sincerely,

Kamala Piske Downing

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



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered August 10, 2016

Mr. Alex Dysthe, Administrator Tuff Memorial Home 505 East 4th Street Hills, MN 56138

RE: Project Number S5548025

Dear Mr. Dysthe:

On July 7, 2016, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective July 31, 2016. (42 CFR 488.422)

This was based on the deficiencies cited by this Department for a standard survey completed on May 19, 2016, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on July 7, 2016. The most serious deficiencies at the time of the revisit were found 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 August 5, 2016, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on July 7, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 3, 2016. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on August 5, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective August 5, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of July 26, 2016. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective August 19, 2016, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective August 19, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective August 19, 2016, is

Tuff Memorial Home August 9, 2016 Page 2 to be rescinded.

In our letter of July 26, 2016, we advised you that, in accordance with Federal law, as specified qin the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for qtwo years from August 19, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on August 5, 2016, the original triggering remedy, denial qof payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

Kumalu Piske Downing

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

POST-CERTIFICATION REVISIT REPORT

				DATE OF REVISI	Т
IDENTIFICATION NUMBER	A. Building				
245548 y1	B. Wing	N N N N N N N N N N N N N N N N N N N	Y2	8/5/2016	Y3
11			12		10
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
TUFF MEMORIAL HOME		505 EAST 4TH STREET			
		HILLS. MN 56138			

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

ITEM DATE		ITEM	DATE	ITEM	DATE			
Y4	Y5	Y4	Y5	Y4	Y5			
ID Prefix F0282	Correction	ID Prefix F0312		ID Prefix	Correction			
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25	^{5(a)(3)} Completed	Reg. #	Completed			
LSC	08/05/2016	LSC	08/05/2016					
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction			
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed			
LSC		LSC		LSC				
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction			
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed			
LSC		LSC		LSC				
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction			
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed			
LSC		LSC		LSC				
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction			
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed			
LSC		LSC		LSC				
REVIEWED BY STATE AGENCY		DATE	SIGNATURE OF SURVEYOR		DATE			
	(INITIALS) KS/kfd	8/10/2016		22113	8/5/2016			
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE		DATE			
FOLLOWUP TO SURVEY COMPLETED ON 5/19/2016		CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?						



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically Delivered

NOTICE OF TOTAL AMOUNT OF ASSESSMENT FOR NURSING HOMES

August 10, 2016

Mr. Alex Dysthe, Administrator Tuff Memorial Home 505 East 4th Street Hills, MN 56138

RE: Project Number S5548025

Dear Mr. Dysthe:

On August 5, 2016 a Notice of Assessment for Noncompliance with Correction Orders was issued to the above facility. That Notice, which was received by the facility on July 26, 2016 imposed a daily fine in the amount of \$750.00.

An acknowledgement was electronically received by the Department stating that the violations had been corrected. A reinspection was held on August 5, 2016 and it was determined that compliance with the licensing rules was attained. A copy of the State Form: Revisit Report from this visit is being delivered electronically.

Therefore, the total amount of the assessment is \$750.00. In accordance with Minnesota Statutes, section 144A.10, subdivision 7, the costs of the reinspection, totaling \$208.00, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of \$958.00 within 15 days of the receipt of this notice. That check should be forwarded to the Department of Health, Health Regulation Division, 85 East Seventh Place, Suite 220, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

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.

Sincerely,

Kumala Fiske Downing

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

cc: Program Assurance Unit Penalty Assessment Deposit Staff

STATE FORM: REVISIT REPORT

	MULTIPLE CONSTRUCTION			DATE OF REVIS	IT
IDENTIFICATION NUMBER	A. Building				
00576 _{Y1}	B. Wing	Y	(2	8/5/2016	Y3
NAME OF FACILITY	-	STREET ADDRESS, CITY, STATE, ZIP CODE			
TUFF MEMORIAL HOME		505 EAST 4TH STREET			
		HILLS, MN 56138			

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).

ITEI	M	DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix	20565	Correction	ID Prefix 209	920	Correction	ID Prefix		Correction
	MN Rule 4658.0 Subp. 3	0405 Completed		Rule 4658.0525 pp. 6 B	Completed	Reg. #		Completed
LSC		08/05/2016	LSC		08/05/2016	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC		-	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC					-	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC		-	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC		-	LSC		
REVIEWE			DATE	SIGNATURE OF	SURVEYOR		DATE	
STATE AG	GENCY	(INITIALS) KS/kfd	8/10/2016		22	113	8/5	/2016
REVIEWE CMS RO		REVIEWED BY (INITIALS)	DATE	TITLE			DATE	
FOLLOWUP TO SURVEY COMPLETED ON 5/19/2016		CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?						

DEPARTMENT OF HEALTH	AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES		
	MEDICA	ARE/MEDICAI	D CERTIFIC	CATION A	ON AND TRANSMITTAL ID: QFKO			
	PART I -	TO BE COMPI	LETED BY 1	THE STAT	TE SURVEY AGENCY	Facility ID: 00576		
1. MEDICARE/MEDICAID PROVIDE NO.(L1) 245548	R	3. NAME AND AL (L3) TUFF MEM				4. TYPE OF ACTION: <u>7</u> (L8) 1. Initial 2. Recertification		
2. STATE VENDOR OR MEDICAID	NO.	(L4) 505 EAST 4			- (130	3. Termination 4. CHOW		
(L2) 230743000		(L5) HILLS, MN			(L6) 56138	5. Validation 6. Complaint 7. On-Site Visit 9. Other		
5. EFFECTIVE DATE CHANGE OF O (L9)	WNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEC	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint		
6. DATE OF SURVEY 07/0	7/2016 ^(L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)		
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID		09/30		
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30		
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:				
From (a):		A. In Complia			And/Or Approved Waivers Of	0 1		
To (b):		0	equirements e Based On:		2. Technical Personnel			
			cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SN	7. Medical Director		
12. Total Facility Beds	50 (L18)	1. A	cceptable POC			 NF)8. Patient Room Size 9. Beds/Room 		
13.Total Certified Beds	50 (L17)	X B. Not in Con			5. Life Safety Code			
		Requirements	and/or Applied	Waivers:	* Code: B *	(L12)		
14. LTC CERTIFIED BED BREAKDOW					15. FACILITY MEETS	(115)		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
50	(1.20)	(1.42)	(1.42)					
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMA	RKS (IF APPLICA	BLE SHOW LTC CA	NCELLATION	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:		
Wendy Buckholz, HF	E NE II		/2/2016	(L19)	Kamala Fiske-Downing, Health	Program Representative 8/26/2016 (L20)		
PAR	T II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	OFFICE OR SINGLE S	TATE AGENCY		
19. DETERMINATION OF ELIGIBILI	ТҮ	20. COM	IPLIANCE WIT	H CIVIL		ncial Solvency (HCFA-2572)		
 Facility is Eligible to Pa 	rticipate	RIGH	ITS ACT:		 Ownership/Control Both of the Above 	bl Interest Disclosure Stmt (HCFA-1513)		
2. Facility is not Eligible	-							
	(L21)							
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	: (L30)		
OF PARTICIPATION	BEGINNING	6 DATE	ENDING DA	TE	VOLUNTARY 00	INVOLUNTARY		
03/01/1991					01-Merger, Closure	05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	oo run to meet igitement		
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	UTHER		
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change		
(L27)	B Rescind St	spension Date:	(L44)			00-Active		
	D. Reseniu St	ispension Date.	(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/			30. REMARKS			
20. TERMINATION DATE.	2)	03001	C/IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII		50. REWARKS			
	(L28)	03001		(L31)				
				(1.01)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAI	DATE				
	(L32)			(L33)	DETERMINATION APP	ROVAL		



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7013 3020 0001 8869 1272

July 26, 2016

Mr. Alex Dysthe, Administrator Tuff Memorial Home 505 East 4th Street Hills, MN 56138

RE: Project Number S5548025

Dear Mr. Dysthe:

On June 1, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 19, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On July 7, 2016, the Minnesota Department of Health and on July 5, 2016, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 19, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 28, 2016. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on May 19, 2016. The deficiencies not corrected are as follows:

F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan F0312 -- S/S: D -- 483.25(a)(3) -- Adl Care Provided For Dependent Residents

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

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

• State Monitoring effective July 31, 2016. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b)

require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective August 19, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective August 19, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 19, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Tuff Memorial Home is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective August 19, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

Tuff Memorial Home July 26, 2016 Page 3 than sixty (60) days after receiving this letter, by mailing to the following address:

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor Health Regulation Division Minnesota Department of Health 1400 E. Lyon Street Marshall, Minnesota 56258 Email: <u>Kathryn.serie@state.mn.us</u> Office: (507) 476-4233 Fax: (507) 537-7194

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.

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 remedy be imposed:

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human

Services that your provider agreement be terminated by November 19, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

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

Date: August 2nd, 2016

TO: Kathryn Serie, Minnesota Department of Health

RE: Tuff Memorial Home, Hills, MN: Plan of Correction

From: Alex Dysthe, Acting Administrator

The following measures have been identified to correct this deficiency:

F282 & F312

ciency: Krob approved 8/2/16

- 1. Each resident's oral care needs have been assessed and education has been provided to staff regarding specific oral care needs.
- 2. DON and MDS Coordinators visited with residents and staff about resident's requests/preferences for oral care.
- 3. Care plans have been updated by DON and MDS Coordinators based upon resident oral care status and preferences.
- 4. Mandatory in-service was done with all staff and each staff was observed at oral care skills lab.
- 5. Oral care skills lab were completed on 7/21/2016 and 7/27/2016.
- 6. All staff have signed statement of understanding the importance of completing oral care.
- 7. Oral care audits will continue to be completed weekly, and education provided to staff when audit shows non-compliance. Audits will be reviewed monthly at quality assurance meeting. The
- 8. The Director of Nursing and Assistant DON will monitor for compliance.
- 9. The Tuff Memorial Home will be in compliance August 3^{rd} , 2016.

RECEIVED

AUG 02 2016

Manestoa Department of Health Marshall

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPR							
		& MEDICAID SERVICES	T			0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	COM	E SURVEY PLETED	
		245548	B. WING _		-	२ 0 7/2016	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
TUFF ME	MORIAL HOME			505 EAST 4TH STREET HILLS, MN 56138			
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENT	ſS	{F 00	0}			
{F 282} SS=D	An onsite Post Cer completed on 7/6/1 deficiencies issued exited on 5/19/16. <i>A</i> deficiencies were u The facility is enroll signature is not req page of the CMS-23 483.20(k)(3)(ii) SEF PERSONS/PER CA The services provic must be provided b accordance with ea care. This REQUIREMEN by: Based on observat review the facility fa related to oral care reviewed for activiti Findings include: R1's quarterly Minir assessment dated required total assist grooming. R1's car indicated R1 had up	tification Revisit (PCR) was 6 and 7/7/16, to follow up on during a recertification survey As a result, the following ncorrected: F282 and F312. ed in ePOC and therefore a uired at the bottom of the first 567 form. RVICES BY QUALIFIED	{F 28				
	lower teeth. R1's cu	indicated R1's teeth should be					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 07/26/2016

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

	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/26/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	0	(X3) DATE COM	E SURVEY PLETED
		245548	B. WING				R 0 7/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE		
TUFF ME	EMORIAL HOME			505 EAST 4TH STREET HILLS, MN 56138			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
{F 282}	nursing assistants (personal cares for F and swabbed once questioned whether that he had upper d them in the mouth s eat better without th lower teeth when of During interview on stated R1's denture he lost so much we don't put them in his stated he had lower them, they just get s told to do." When interviewed of director of nursing (natural teeth should and toothpaste not DON verified staff of related to oral care. R26's significant ch assessment dated required extensive a grooming. R26's pl 4/18/16, indicated F dentures and nine (R26's care plan lass that R26 had Lewy assistance to place [dentures] at hour of cup. The care plan teeth should be bru	on 7/7/16, at 7:37 a.m. NA)-F and NA-J performed R1. NA-F used a toothette around R1's mouth. When r R1 had teeth, NA-F replied lentures but staff do not place since they don't fit and R1 can nem. NA-F did not brush R1's oserved. 7/7/16, at 12:01 p.m. NA-J s don't fit anymore because ight and consequently staff s mouth anymore. She also r teeth but "we don't brush swabbed, that's what we were on 7/7/16, at 11:04 a.m. the DON) confirmed R1's lower d be brushed with a toothbrush swabbed with a toothbrush swabbed with a toothette. lid not follow R1's care plan	{F 282				

If continuation sheet Page 2 of 7

	MENT OF HEALTH		FORM	APPROVED				
		& MEDICAID SERVICES				MB NO. 0938-0391		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		IPLE CONSTRUCTION		E SURVEY IPLETED	
			A. BOILD		IG	,	R	
		245548	B. WING				07/2016	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
	MORIAL HOME				505 EAST 4TH STREET			
					HILLS, MN 56138			
(X4) ID			ID	v	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION	
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		CROSS-REFERENCED TO THE APPROP		DATE	
					DEFICIENCY)			
(5.000)								
{F 282}	Continued From pa	-	{F 28	82	2}			
	Assistant assignme	ent sheet, indicated R26 was to						
		neu.						
		a.m. NA-F and NA-J were						
		ng morning (AM) cares for						
		erved lying in bed with his top ien the surveyor entered R26's						
		A-J were observed to provide						
		are, and dressed the resident						
		transferring him into his						
		ransferred, the NA's assisted is face and combing hair.						
		eled to the lounge area to						
		or to breakfast. It was						
	observed that neith	er NA provided oral hygiene						
	for R26 during more	ning cares.						
	When interviewed o	on 7/07/16, at 9:00 a.m. NA-J						
		not provided oral care for R26						
	during or prior to the	e observation of AM cares.						
		cing R26's upper denture in						
		ne surveyor entering the room. Id brushed R26's upper						
		cement and further stated she						
		s mouth with a toothette						
		rior to the placement of the						
		J confirmed R26 had natural						
		and verified she did not brush th with a toothbrush.						
		on 7/07/16, at 11:04 a.m. the						
		(DON) confirmed R26's lower						
		be brushed with a toothbrush ng morning and bedtime						
	cares per the plan of							
		Home Care Plan policy, last						
		dicated each care plan would 90 days as required by law.						

If continuation sheet Page 3 of 7

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP	OI PLE CONSTRUCTION	MB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	DENTIFICATION NUMBER:			G		PLETED
		245548	B. WING				ך 10 7/2016
NAME OF I	PROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
TUFF ME	EMORIAL HOME				505 EAST 4TH STREET HILLS, MN 56138		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	1	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLETION DATE
{F 312} SS=D		ARE PROVIDED FOR	{F 3 [.]	12}	}		
	daily living receives	nable to carry out activities of the necessary services to tion, grooming, and personal					
	by: Based on observat review the facility fa	NT is not met as evidenced tion, interview, and document tiled to provide oral care for 2 R26) reviewed for activities of e.					
	R1's quarterly Minir assessment dated required total assist grooming. An oral/	num Data Set (MDS) 12/21/15, indicated he tance of two staff for dental care area assessment 1 during the prior full MDS					
	upper denture whic fit and staff were to current Nursing Ass	d 6/14/16, indicated R1 had h staff leave out due to poor brush his lower teeth. R1's sistant assignment sheet, n should be brushed.					
	had teeth in the low	Neck/Speech and te dated 6/22/16, indicated R1 rer gum line in very poor ngs and wore dentures that					
		30/15, dental exam identified decay, a large amount of					

If continuation sheet Page 4 of 7

		AND HUMAN SERVICES				FORM	APPROVED	
		& MEDICAID SERVICES				MB NO. 0938-0391		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		E SURVEY PLETED	
			A. BOILD		G		R	
		245548	B. WING			07/	07/2016	
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
TUFF ME	EMORIAL HOME				505 EAST 4TH STREET			
					HILLS, MN 56138 PROVIDER'S PLAN OF CORRECTIO			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
{F 312}	Continued From pa	ge 4	{F 3 [.]	12	2}			
		ne and should have his teeth	,					
	During observation nursing assistants (personal cares for F and swabbed once questioned whether that he had upper d them in the mouth s eat better without th lower teeth. During interview on	on 7/7/16, at 7:37 a.m. NA)-F and NA-J performed R1. NA-F used a toothette around R1's mouth. When r R1 had teeth, NA-F replied lentures but staff do not place since they don't fit and R1 can nem. NA-F did not brush R1's 7/7/16, at 12:01 p.m. NA-J						
	he lost so much we don't put them in his stated he had botto	es don't fit anymore because ight and consequently staff s mouth anymore. She also m teeth but "we don't brush swabbed, that's what we were						
	director of nursing (natural teeth should	on 7/7/16, at 11:04 a.m. the DON) confirmed R1's lower t be brushed with a toothbrush just swabbed with a toothette.						
	assessment dated required extensive	ange in status MDS 4/19/16, indicated R26 assistance of two staff for re Area Assessment (CAA) for id not trigger.						
		assessment dated 4/18/16, oosely fitting upper dentures natural teeth.						
	that R26 had Lewy	t revised on 7/5/16, indicated Body dementia, required staff upper dentures and to soak						

If continuation sheet Page 5 of 7

		AND HUMAN SERVICES				FORM	07/26/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245548	B. WING				R 0 7/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TUFF ME	EMORIAL HOME				05 EAST 4TH STREET HLLS, MN 56138		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 312}	[dentures] at hour of cup. The care plan teeth should be bru The current Nursing indicated R26 was On 7/07/16 at 7:15 observed performin R26. R26 was obse denture in place wh room. NA-F and N catheter care, perior for the day prior to the wheelchair. Once the R26 with washing he R26 was then where watch television prior observed that neith for R26 during more When interviewed of confirmed she had during or prior to the NA-F confirmed pla his mouth prior to the NA-F stated she had denture prior to place also swabbed R26's wetted with water p upper denture. NA- lower teeth present the R26's bottom tee When interviewed of director of nursing (natural teeth should and toothpaste. The	of sleep (HS) in the denture also indicated R26's natural shed with AM and PM cares. g Assistant assignment sheet, to have his teeth brushed. a.m. NA-F and NA-J were ag morning (AM) cares for erved lying in bed with his top hen the surveyor entered R26's A-J were observed to provide eare, and dressed the resident transferring him into his transferred, the NA's assisted his face and combing hair. eled to the lounge area to or to breakfast. It was er NA provided oral hygiene	{F 3	12}			

Facility ID: 00576

If continuation sheet Page 6 of 7

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE			AND HUMAN SERVICES				FORM	APPROVED
At BOILDING R 245548 B. WING 07/07/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE TUFF MEMORIAL HOME STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) ID FOR PROVIDER'S PLAN OF CORRECTION PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETIC DATE	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL		(X3) DATE	E SURVEY
245548 B. WING O7/07/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 505 EAST 4TH STREET TUFF MEMORIAL HOME 505 EAST 4TH STREET HILLS, MN 56138 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETIC DATE (X5) COMPLETIC DATE	AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE TUFF MEMORIAL HOME 505 EAST 4TH STREET (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			245548	B. WING				
TUFF MEMORIAL HOME HILLS, MN 56138 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETIC DATE (X5) COMPLETIC DATE	NAME OF	PROVIDER OR SUPPLIER						
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTIC DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	TUFF ME	EMORIAL HOME						
DEFICIENCY)	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
{F 312} Continued From page 6 lack of oral care continued to be an issue as staff had not consistently provided the appropriate oral hygiene. {F 312}	{F 312}	lack of oral care con had not consistently	ntinued to be an issue as staff	{F 3	12}			

Facility ID: 00576

If continuation sheet Page 7 of 7

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION			DATE OF REVIS	IT
IDENTIFICATION NUMBER	A. Building				
245548 _{Y1}	B. Wing	Y	′2	7/7/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
TUFF MEMORIAL HOME		505 EAST 4TH STREET			
		HILLS, MN 56138			

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).

ITEI	Μ	DATE	ITEN	I		DATE	ITEM			DATE
Y4		Y5	Y4			Y5	Y4			Y5
ID Prefix	F0159	Correctic	n ID Prefix	F0225		Correction	ID Prefix	F0226		Correction
Reg. #	483.10(c)(2)-(5)	Complete	ed Reg. #	483.13 - (4)	(c)(1)(ii)-(iii), (c)(2)	Completed	Reg. #	483.13(c)		Completed
LSC		06/28/201	6 LSC			06/28/2016	LSC			06/28/2016
ID Prefix	F0280	Correctio	n ID Prefix	F0309		Correction	ID Prefix	F0329		Correction
Reg. #	483.20(d)(3), 48 (2)	3.10(k) Complete	ed Reg. #	483.25		Completed	Reg. #	483.25(l)		Completed
LSC		06/28/201	6 LSC			06/28/2016	LSC			06/28/2016
ID Prefix	F0428	Correctio	n ID Prefix	F0441		Correction	ID Prefix	F0465		Correction
Reg. #	483.60(c)	Complete	ed Reg. #	483.65		Completed	Reg. #	483.70(h)		Completed
LSC		06/28/201	6 LSC			06/28/2016	LSC			06/28/2016
ID Prefix		Correctio	n ID Prefix			Correction	ID Prefix			Correction
Reg. #		Complete	ed Reg. #			Completed	Reg. #			Completed
LSC			LSC				LSC			
ID Prefix		Correctic	n ID Prefix			Correction	ID Prefix			Correction
Reg. #		Complete	ed Reg. #			Completed	Reg. #			Completed
LSC			LSC				LSC			
REVIEWE		REVIEWED BY (INITIALS)	DATE		SIGNATURE OF	SURVEYOR			DATE	
		<u>KS/kfd</u>	7/26/20	16			3	81767		2016
REVIEWE		REVIEWED BY (INITIALS)	DATE		TITLE				DATE	
FOLLOW 5/19/201		COMPLETED ON			RANY UNCORREC					s 🗌 no

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01		I	DATE OF REVIS	IT
	B. Wing	Y2	2	7/5/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
TUFF MEMORIAL HOME		505 EAST 4TH STREET			
		HILLS, MN 56138			

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4		DATE Y5
14	15	14	15	14		15
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
NFPA 101 Reg. #	Completed	Reg. #	. 101 Completed	Reg. #		Completed
LSC K0025	05/23/2016	LSC K014	7 05/23/2016	LSC		
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #	Completed	Reg. #		Completed
LSC		LSC		LSC		
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #	Completed	Reg. #		Completed
		LSC		LSC		
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #	Completed	Reg. #		Completed
LSC		LSC		LSC		
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #	Completed	Reg. #		Completed
LSC		LSC		LSC		
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR		DATE	
	TL/kfd	7/26/2016		35482		5/2016
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE		DATE	
FOLLOWUP TO SURVE 5/17/2016	EY COMPLETED ON		OR ANY UNCORRECTED DEFICIE CTED DEFICIENCIES (CMS-2567			5 🗆 NO



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

REVISED LETTER

Electronically Delivered

NOTICE OF TOTAL AMOUNT OF ASSESSMENT FOR NURSING HOMES

August 18, 2016

Mr. Alex Dysthe, Administrator Tuff Memorial Home 505 East 4th Street Hills, MN 56138

RE: Project Number S5548025

Dear Mr. Dysthe:

Please note that the fine amount has been changed to reflect the corrected amount.

On August 5, 2016 a Notice of Assessment for Noncompliance with Correction Orders was issued to the above facility. That Notice, which was received by the facility on July 26, 2016 imposed a daily fine in the amount of \$650.00.

An acknowledgement was electronically received by the Department stating that the violations had been corrected. A reinspection was held on August 5, 2016 and it was determined that compliance with the licensing rules was attained. A copy of the State Form: Revisit Report from this visit is being delivered electronically.

Therefore, the total amount of the assessment is \$650.00. In accordance with Minnesota Statutes, section 144A.10, subdivision 7, the costs of the reinspection, totaling \$208.00, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of \$858.00 within 15 days of the receipt of this notice. That check should be forwarded to the Department of Health, Health Regulation Division, 85 East Seventh Place, Suite 220, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

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.

Sincerely,

Kumalu Fiske Downing

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

cc: Program Assurance Unit Penalty Assessment Deposit Staff

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		00576	B. WING		R 07/07/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	
TUFF ME	EMORIAL HOME	505 EAST HILLS, MN	4TH STREE N 56138	T	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET
{2 000}	Initial Comments		{2 000}		
	*****ATTEI	NTION*****			
	NH LICENSING	CORRECTION ORDER			
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been			
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ont for non-compliance.			
	07/06/16 and 07/07 was determined that orders/s # 0565, #0 uncorrected order/s be reviewed at the	TS: visit was completed on /16. During this onsite visit it at the following corrections 920 were NOT corrected. This will remain in effect and will next onsite visit. Also will be reviewed for possible		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned to Minnesota state statutes/rules for N Homes.	oftware. to

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMPI	
				·	R	
		00576	B. WING		07/0	7/2016
	PROVIDER OR SUPPLIER		T 4TH STRE	STATE, ZIP CODE ET		
UFF ME	MORIAL HOME		IN 56138			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
{2 000}	Continued From pa	age 1	{2 000}			
	penalty assessmen	nt/s.		The assigned tag number a far left column entitled "ID I The state statute/rule numb corresponding text of the st out of compliance is listed in "Summary Statement of De column and replaces the "To portion of the correction ord column also includes the f are in violation of the state s statement, "This Rule is not evidenced by." Following ti findings are the Suggested Correction and the Time Pe Correction. PLEASE DISREGARD THE THE FOURTH COLUMN W STATES, "PROVIDER'S PL CORRECTION." THIS APP FEDERAL DEFICIENCIES WILL APPEAR ON EACH F THERE IS NO REQUIREM SUBMIT A PLAN OF CORF VIOLATIONS OF MINNESS STATUTES/RULES.	Prefix Tag." er and the ate statute/rule n the ficiencies" o Comply" er. This indings which statute after the met as he surveyors Method of riod For E HEADING OF HICH AN OF LIES TO ONLY. THIS PAGE. ENT TO RECTION FOR	
{2 565}	MN Rule 4658.040 Plan of Care; Use	5 Subp. 3 Comprehensive	{2 565}			
		omprehensive plan of care I personnel involved in the t.				
	This MN Requirem	ent is not met as evidenced				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED R
		00576	B. WING		07/	07/2016
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
TUFF ME	EMORIAL HOME	505 EAST HILLS, M	「4TH STREET N 56138	ſ		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
{2 565}	The original licensir remain in effect. Per Based on observati review the facility far related to oral care reviewed for activiti Findings include: R1's quarterly Mininassessment dated required total assist grooming. R1's car indicated R1 had up out due to poor fit a lower teeth. R1's cu assignment sheet, it brushed. During observation nursing assistants (personal cares for F and swabbed once questioned whether that he had upper of them in the mouth s eat better without th lower teeth when of During interview on stated R1's denture he lost so much we don't put them in his stated he had lower	d on the following findings. Ing order issued on 5/19 /16 will enalty assessment issued." on, interview, and document iled to follow the plan of care for 2 of 4 residents (R1, R26) es of daily living/oral care. num Data Set (MDS) 12/21/15, indicated he cance of two staff for re plan dated 6/14/16, oper denture which staff leave and staff were to brush his irrent Nursing Assistant indicated R1's teeth should be on 7/7/16, at 7:37 a.m. NA)-F and NA-J performed R1. NA-F used a toothette around R1's mouth. When r R1 had teeth, NA-F replied lentures but staff do not place since they don't fit and R1 can nem. NA-F did not brush R1's	{2 565}			

ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	00576	B. WING			R 07/2016
PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
MORIAL HOME		-	г		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
When interviewed director of nursing natural teeth should and toothpaste not DON verified staff or related to oral care R26's significant chassessment dated required extensive grooming. R26's p 4/18/16, indicated F dentures and nine R26's care plan lass that R26 had Lewy assistance to place [dentures] at hour of cup. The care plan teeth should be bruc PM (evening) cares	on 7/7/16, at 11:04 a.m. the (DON) confirmed R1's lower d be brushed with a toothbrush swabbed with a toothette. did not follow R1's care plan nange in status MDS 4/19/16, indicated R26 assistance of two staff for hysical/oral assessment dated R26 had loosely fitting upper (9) lower natural teeth. at revised on 7/5/16, indicated Body dementia, required staff e upper dentures and to soak of sleep (HS) in the denture n also indicated R26's natural ushed with AM (morning) and s. The current Nursing				
On 7/07/16 at 7:15 observed performin R26. R26 was obs denture in place wh room. NA-F and N catheter care, perio for the day prior to wheelchair. Once R26 with washing h R26 was then whee watch television pri observed that neith for R26 during mor	a.m. NA-F and NA-J were ng morning (AM) cares for erved lying in bed with his top nen the surveyor entered R26's A-J were observed to provide care, and dressed the resident transferring him into his transferred, the NA's assisted his face and combing hair. eled to the lounge area to for to breakfast. It was her NA provided oral hygiene ning cares.	3			
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENC) REGULATORY OR L Continued From para When interviewed of director of nursing natural teeth should and toothpaste not DON verified staff of related to oral care R26's significant ch assessment dated required extensive grooming. R26's p 4/18/16, indicated I dentures and nine R26's care plan lass that R26 had Lewy assistance to place [dentures] at hour of cup. The care plan that R26 had Lewy assistance to place [dentures] at hour of cup. The care plan that R26 had Lewy assistant assignment have his teeth brus On 7/07/16 at 7:15 observed performing R26. R26 was observed denture in place who room. NA-F and N catheter care, period for the day prior to wheelchair. Once and R26 was then when watch television priod observed that neither for R26 during more	OF CORRECTION IDENTIFICATION NUMBER: 00576 00576 PROVIDER OR SUPPLIER STREET AL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 When interviewed on 7/7/16, at 11:04 a.m. the director of nursing (DON) confirmed R1's lower natural teeth should be brushed with a toothbrush and toothpaste not swabbed with a toothette. DON verified staff did not follow R1's care plan related to oral care. R26's significant change in status MDS assessment dated 4/19/16, indicated R26 required extensive assistance of two staff for grooming. R26's physical/oral assessment dated 4/18/16, indicated R26 had loosely fitting upper dentures and nine (9) lower natural teeth. R26's care plan last revised on 7/5/16, indicated that R26 had Lewy Body dementia, required staff assistance to place upper dentures and to soak [dentures] at hour of sleep (HS) in the denture cup. The care plan also indicated R26's natural teeth should be brushed with AM (morning) and PM (evening) cares. The current Nursing Assistant assignment sheet, indicated R26 was to have his teeth brushed. On 7/07/16 at 7:15 a.m. NA-F and NA-J were observed performing morning (AM) cares for R26. R26 was observed lying in bed with his top	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00576 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 3 {2 565} When interviewed on 7/7/16, at 11:04 a.m. the director of nursing (DON) confirmed R1's lower natural teeth should be brushed with a toothbrush and toothpaste not swabbed with a toothette. DON verified staff did not follow R1's care plan related to oral care. R26's significant change in status MDS assessment dated 4/19/16, indicated R26 required extensive assistance of two staff for grooming. R26's physical/oral assessment dated 4/18/16, indicated R26 had loosely fitting upper dentures and nine (9) lower natural teeth. R26's care plan last revised on 7/5/16, indicated that R26 had Lewy Body dementia, required staff assistance to place upper dentures and to soak [dentures] at hour of sleep (HS) in the denture cup. The care plan also indicated R26's natural teeth should be brushed with AM (morning) and PM (evening) cares. The current Nursing Assistant assignment sheet, indicated R26 was to have his teeth brushed. On 7/07/16 at 7:15 a.m. NA-F and NA-J were observed performing morning (AM) cares for R26. R26 was observed lying in bed with his top denture in place when the surveyor entered R26's room. NA-F and NA-J were observed to provide catheter care, pericare, and dressed the resident for the day prior to tr	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00576 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER OR DEFICIENCY MILLS, MN 56138 PROVIDER'S PLAN OF SUMMARY STATEMENT OF DEFICIENCIES ID REGULATORY OR LSC IDENTIFYING INFORMATION PREPK TAG COntinued From page 3 (2 565) When interviewed on 7/7/16, at 11:04 a.m. the (EACH DEVISE) driver of nursing (DON) confirmed R1's lower CONS REFERENCED TO DOTAL COMPACTION NUMBER: DEFICIENCY MUSA Auto tothpaste not swabbed with a tootherte. DON verified staff did not follow R1's care plan Pater About De Tuber Company R26's significant change in status MDS assessment dated 4/19/16, indicated R26 required extensive assistance of two staff for grooming. R26's physical/oral assessment dated 4/18/16, indicated R26 had loosely fitting upper dentures and ine (9) lower natural teeth. R26's care plan last revised on 7/5/16, indicated R26 was to nave his teeth brushed. On 7/07/16 at 7:15 a.m. NA-F and NA-J were obsk Assistant assignment sheet, indicated R26 was to nave his teeth br	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: COM 00576 B. WING 077 PROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE 505 EAST 4TH STREET MORIAL HOME STREET ADDRESS, CITY, STATE, ZIP CODE PROVIDERS PLAND OF CORRECTION IEEQLATORY ONLSTD EPRICEDED BY FULL PRESULATORY ONLSTD EPRICEDED BY FULL PRESULATORY ONLSTD EPRICEDED BY FULL IEEQLATORY ONLSTD EPRICEDED BY FULL PRESULATORY ONLSTD EPRICEDED BY FULL PRESULATORY ONLSTD EPRICEDED BY FULL Metaor Deficiencies IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: Continued From page 3 (2 565) IDENTIFICATION THING INFORMATION) IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: Continued From page 3 (2 565) IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: Continued From page 3 (2 565) IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: DON vortified staff did not follow R1's care plan IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: R26's care plan last revised on 7/5/16, indicated flat IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: IDENTIFICATION NUMBER:

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. DOILDING.			R
		00576	B. WING		07/	07/2016
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
TUFF ME	EMORIAL HOME	505 EAS HILLS, M	「 4TH STREET N 56138			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
{2 565}	Continued From pa	age 4	{2 565}			
	NA-F confirmed pla his mouth prior to t NA-F stated she ha denture prior to pla also swabbed R26 wetted with water p upper denture. NA- lower teeth present the R26's lower teet When interviewed director of nursing natural teeth should and toothpaste dur cares per the plan The Tuff Memorial	ne observation of AM cares. acing R26's upper denture in he surveyor entering the room. ad brushed R26's upper accement and further stated she 's mouth with a toothette orior to the placement of the -J confirmed R26 had natural t and verified she did not brush eth with a toothbrush. on 7/07/16, at 11:04 a.m. the (DON) confirmed R26's lower d be brushed with a toothbrush ing morning and bedtime of care. Home Care Plan policy, last ndicated each care plan would				
(0.000)	be reviewed every	90 days as required by law.	(0.000)			
{2 920}	Subp. 6. Activities comprehensive res home must ensure B. a resident who activities of daily liv	o is unable to carry out ring receives the necessary n good nutrition, grooming,	{2 920}			
	by: "Uncorrected base The original licensi	ent is not met as evidenced d on the following findings. ng order issued on 5/19 /16 will renalty assessment issued."				
	Based on observat	ion, interview and document				

STATE FORM

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	COM	E SURVEY PLETED		
		00576	B. WING			07/07/2016		
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE				
TUFF ME	EMORIAL HOME		T 4TH STREE ⁻ IN 56138	Т				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE		
{2 920}	Continued From pa	ige 5	{2 920}					
	completed for 2 of	ailed to ensure oral cares were 4 residents (R1, R26) es of daily living (ADL).						
	Findings include:							
	assessment dated required total assis grooming. An oral/	num Data Set (MDS) 12/21/15, indicated he tance of two staff for dental care area assessment 1 during the prior full MDS						
	upper denture whic fit and staff were to current Nursing Ass	ed 6/14/16, indicated R1 had h staff leave out due to poor brush his lower teeth. R1's sistant assignment sheet, n should be brushed.						
	had teeth in the low	Neck/Speech and te dated 6/22/16, indicated R1 ver gum line in very poor ngs and wore dentures that						
	that R1's teeth had	30/15, dental exam identified decay, a large amount of ne and should have his teeth r day.						
	nursing assistants of personal cares for and swabbed once questioned whethe that he had upper of them in the mouth s	on 7/7/16, at 7:37 a.m. (NA)-F and NA-J performed R1. NA-F used a toothette around R1's mouth. When r R1 had teeth, NA-F replied dentures but staff do not place since they don't fit and R1 can nem. NA-F did not brush R1's						

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	NT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED		
		00576	B. WING			07/07/2016		
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE				
TUFF MI	EMORIAL HOME	505 EAS HILLS, M	T 4TH STREET N 56138	r				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE		
{2 920}	stated R1's denture he lost so much we don't put them in hi stated he had botto them they just get s told to do." When interviewed of director of nursing (natural teeth should and toothpaste not R26's significant ch assessment dated required extensive grooming. The Car oral/dental status d R26's physical/oral indicated R26 had I and nine (9) lower r R26's care plan las that R26 had Lewy assistance to place [dentures] at hour of cup. The care plan teeth should be bru The current Nursing indicated R26 was On 7/07/16 at 7:15 observed performin R26. R26 was obs denture in place wh	2 7/7/16, at 12:01 p.m. NA-J es don't fit anymore because bight and consequently staff s mouth anymore. She also im teeth but "we don't brush swabbed, that's what we were on 7/7/16, at 11:04 a.m. the (DON) confirmed R1's lower d be brushed with a toothbrush just swabbed with a toothbrush just swabbed with a toothbrush 4/19/16, indicated R26 assistance of two staff for re Area Assessment (CAA) for id not trigger. assessment dated 4/18/16, loosely fitting upper dentures						

Minnesota Department of Health STATE FORM

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If continuation sheet 7 of 8

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING: _				
		00576	B. WING			R 07/07/2016	
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
UFF ME	EMORIAL HOME		T 4TH STREET	r			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
{2 920}	Continued From pa	age 7 transferred, the NA's assisted	{2 920}				
	R26 with washing h R26 was then when watch television pri	his face and combing hair. eled to the lounge area to ior to breakfast. It was her NA provided oral hygiene					
	confirmed she had during or prior to th NA-F confirmed pla his mouth prior to t NA-F stated she had denture prior to pla	on 7/07/16, at 9:00 a.m. NA-J not provided oral care for R26 the observation of AM cares. acing R26's upper denture in the surveyor entering the room. ad brushed R26's upper acement and further stated she					
	wetted with water p upper denture. NA- teeth present and v R26's bottom teeth						
	director of nursing natural teeth should and toothpaste. Th the toothbrushing a lack of oral care co	on 7/07/16, at 11:04 a.m. the (DON) confirmed R26's lower d be brushed with a toothbrush ne DON further confirmed per audits she had conducted, that ontinued to be an issue as staff by provided the appropriate oral					

QFKO12

STATE FORM: REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building			DATE OF REVIS	SIT
	B. Wing		Y2	7/7/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
TUFF MEMORIAL HOME		505 EAST 4TH STREET			
		HILLS, MN 56138			

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

ITE Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
		15	14		15	14		15
ID Prefix	20302	Correction	ID Prefix	20570	Correction	ID Prefix	20830	Correction
Reg. #	MN State Statute 144.6503	Completed		MN Rule 4658.0405 Subp. 4	Completed	Reg. #	MN Rule 4658.0520 Subp. 1	Completed
LSC		07/07/2016	LSC		06/28/2016	LSC		06/28/2016
ID Prefix	21390	Correction	ID Prefix	21530	Correction	ID Prefix	21540	Correction
Reg. #	MN Rule 4658.080 Subp. 4 A-I	00 Completed		MN Rule 4658.1310 A.B.C	Completed	Reg. #	MN Rule 4658.1315 Subp. 2	Completed
LSC		06/28/2016	LSC		06/28/2016	LSC		06/28/2016
ID Prefix	21685	Correction	ID Prefix	21910	Correction	ID Prefix	21980	Correction
Reg. #	MN Rule 4658.141 Subp. 2	5 Completed		MN St. Statute 144.65 Subd. 25	¹ Completed	Reg. #	MN St. Statute 626. Subd. 3	557 Completed
LSC		06/28/2016	LSC		06/28/2016	LSC		06/28/2016
ID Prefix	21995	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	MN St. Statute 620 Subd. 4a	6.557 Completed	Reg. #		Completed	Reg. #		Completed
LSC		06/28/2016	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
REVIEW		REVIEWED BY	DATE	SIGNATURE	OF SURVEYOR		D	ATE
STATE A		INITIALS) KS/kfd	7/26/201	16	3	1767		7/7/2016
REVIEW		REVIEWED BY INITIALS)	DATE	TITLE			D	ATE
FOLLOWUP TO SURVEY COMPLETED ON 5/19/2016			CK FOR ANY UNCORF DRRECTED DEFICIEN				YES 🗌 NO	

STATE FORM: REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building			DATE OF REVI	SIT
	B. Wing		Y2	7/7/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
TUFF MEMORIAL HOME		505 EAST 4TH STREET			
		HILLS, MN 56138			

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

ITE			ATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix	20302	Corr	ection	ID Prefix	20570		Correctio	n ID Prefix	20830		Correction
Reg. #	MN State Statute 144.6503	e Com	pleted	Reg. #	MN Rul Subp. 4	e 4658.0405	Complete	d Reg. #	MN Rule 4658.05 Subp. 1	20	Completed
LSC		07/07	7/2016	LSC			06/28/201	B LSC			06/28/2016
ID Prefix	21390	Corr	ection	ID Prefix	21530		Correctio	n ID Prefix	21540		Correction
Reg. #	MN Rule 4658.0 Subp. 4 A-I	800 Com	pleted	Reg. #	MN Rul A.B.C	e 4658.1310	Complete	d Reg. #	MN Rule 4658.13 Subp. 2	15	Completed
LSC		06/28	3/2016	LSC			06/28/201	5 LSC			06/28/2016
ID Prefix	21685	Corr	ection	ID Prefix	21910		Correctio	n ID Prefix	21980		Correction
Reg. #	MN Rule 4658.1 Subp. 2	415 Com	pleted	Reg. #	MN St. Subd. 2	Statute 144.65 ⁻ 25	1 Complete	d Reg. #	MN St. Statute 62 Subd. 3	26.557	Completed
LSC		06/28	8/2016	LSC			06/28/201	5 LSC			06/28/2016
ID Prefix	21995	Corr	ection	ID Prefix			Correctio	n ID Prefix			Correction
Reg. #	MN St. Statute 6 Subd. 4a	26.557 Com	pleted	Reg. #			Complete	d Reg. #			Completed
LSC		06/28	3/2016	LSC				LSC			
ID Prefix		Corr	ection	ID Prefix			Correctio	n ID Prefix			Correction
Reg. #		Com	pleted	Reg. #			Complete	d Reg. #			Completed
LSC				LSC				LSC			
REVIEW		REVIEWED B (INITIALS) KS/kfd	Y	DATE 7/26/20	16	SIGNATURE C	OF SURVEYO	31767		DATE	7/2016
REVIEW CMS RO		REVIEWED B' (INITIALS)	Y	DATE	10	TITLE		01101		DATE	
FOLLOWUP TO SURVEY COMPLETED ON 5/19/2016			ON			ANY UNCORF			A SUMMARY OF THE FACILITY?		6 🗌 NO

DEPARTMENT OF HEALTH AND	D HUMA	N SERVICES	CENTERS FOR MED	ICARE & MEDICAID SERVICES	
		ARE/MEDICAID CERTIFICATION		ID: QFKO	
	PART I -	TO BE COMPLETED BY THE STAT	FE SURVEY AGENCY	Facility ID: 00576	
1. MEDICARE/MEDICAID PROVIDER NO.(L1) 245548		3. NAME AND ADDRESS OF FACILITY (L3) TUFF MEMORIAL HOME		 TYPE OF ACTION: <u>2</u>(L8) Initial Recertification 	
2. STATE VENDOR OR MEDICAID NO. (L2) 230743000		(L4) 505 EAST 4TH STREET (L5) HILLS, MN	(L6) 56138	3. Termination 4. CHOW 5. Validation 6. Complaint 7. O. Str. Virtue 0. Other	
5. EFFECTIVE DATE CHANGE OF OWNER (L9)	RSHIP	 PROVIDER/SUPPLIER CATEGORY 11 Hospital 15 HHA 16 ESRD 	<u>02</u> (L7) 13 PTIP 22 CLIA	 7. On-Site Visit 9. Other 8. Full Survey After Complaint 	
6. DATE OF SURVEY 05/19/20 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	16 (L34) (L10)	02 SNF/NF/Dual 06 PRTF 10 NF 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 04 SNF 08 OPT/SP 12 RHC	14 CORF) 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30	
•) (L18)) (L17)	10.THE FACILITY IS CERTIFIED AS: A. In Compliance With Program Requirements Compliance Based On: 1. Acceptable POC X B. Not in Compliance with Program	And/Or Approved Waivers Of T 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	
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF	19 SNF	Requirements and/or Applied Waivers: ICF IID	* Code: B * 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L12) (L15)	
50	19 5141		1801 (c) (1) 01 1801 (j) (1).		
(L37) (L38)	(L39)	(L42) (L43)			
16. STATE SURVEY AGENCY REMARKS (TE APPLICA	BLE SHOW LTC CANCELLATION DATE)			
17. SURVEYOR SIGNATURE		Date :	18. STATE SURVEY AGENCY A	APPROVAL Date:	
Susan Kalis, HFE NE II		06/20/2016 (L19)	Kamala Fiske-Downing, Health Program Representative 07/15/2016 (L20)		
PART II -	- TO BE	COMPLETED BY HCFA REGIONAL	L OFFICE OR SINGLE ST	· · · ·	
 DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participat 2. Facility is not Eligible 	te (L21)	20. COMPLIANCE WITH CIVIL RIGHTS ACT:	 Statement of Finance Ownership/Control Both of the Above : 	Interest Disclosure Stmt (HCFA-1513)	
22. ORIGINAL DATE 23. L	TC AGREE	MENT 24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)	
	BEGINNINC		VOLUNTARY 00 01-Merger, Closure		
(L24) (L41)	(L25)	02-Dissatisfaction W/ Reimburser	· · · · · · · · · · · · · · · · · · ·	
		VE SANCTIONS a of Admissions: (L44)	03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	O <u>THER</u> 07-Provider Status Change 00-Active	
(L27) B	B. Rescind Su	(L++)		oo neare	
		(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/CARRIER NO.	30. REMARKS		
		03001			
(L2	28)	(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION OF APPROVAL DATE			
(L3	(2)	(L33)	DETERMINATION APPR	OVAL	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7013 3020 0001 8869 1029

June 1, 2016

Mr. Alex Dysthe, Administrator Tuff Memorial Home 505 East 4th Street Hills, MN 56138

RE: Project Number S5548025

Dear Mr. Dysthe:

On May 19, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

<u>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;

Potential Consequences - 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, Unit Supervisor Health Regulation Division Minnesota Department of Health 1400 E. Lyon Street Marshall, Minnesota 56258 Email: <u>Kathryn.serie@state.mn.us</u> Office: (507) 476-4233 Fax: (507) 537-7194

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 June 28, 2016, 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 August 19, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 19, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

> Nursing Home Informal Dispute Process Minnesota Department of Health 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145

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

Feel free to contact me if you have questions.

Sincerely,

Kumala Piske Downing

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

505 E. 4th Street Hills, MN 56138

Phone: 507-962-3275 Fax: 507-962-3277

6/6/16 Ante

compliance

attend /revie



TUFF MEMORIAL HOME, INC. Tuff Village Assisted Living & Tuff Retirement Apartments

RECEIVED

JUN 15 2016 Munestoa Department of Health

Marchall

Date: July 6th, 2016

TO: Kathryn Serie, Minnesota Department of Health

RE: Tuff Memorial Home, Hills, MN: Plan of Correction

From: Alex Dysthe, Acting Administrator

approved 6/16 The following measures have been identified to correct this deficiency: CNA mtg to reviewallingo-4/1/16

- F159 483.10(c) (2)-(5) Facility Management of Personal Funds
 - 1. We will inform the resident's their legal representatives of the statute requiring a max of \$50 in their resident trust account.
 - 2. Any resident with personal funds over \$50 in their trust account will have the excess amount sent to their legal representative or put in their personal bank account based on situation - completed on 6-15-16
 - sentst 3. Quarterly statements will be sent out to the resident or his or her legal representative on 6
 - 4. The Administrator and Accountant will monitor compliance with this correction of ACounter 5. The Tuff Memorial Home will be in compliance by June 28th, 2016. Report to ACounter the Accounter of Accounter Account

F225 483.13(c) (2)-(4) Investigate/Report Allegations/Individuals Mutses trained heck unwitnessed Staff will be trained on the importance of reporting of all neglect/abuse situations to the

- 2. The Director of Nursing and Administrator will monitor compliance with this correction.
 - The Tuff Memorial Home will be in compliance by June 28th, 2016

daily Falls/incidents reviewed by DON -ement Abuse/Neglect, Etc. Policies repated to ad 483.13(c) Develop/Implement Abuse/Neglect, Etc. Policies

mo. DON up dates VAA/incid VAA/incid reports

1. Staff will be trained on the importance of reporting of all neglect/abuse situations to the administrator and State Agencies immediately in accordance to State law. The proper steps will be taken by the Administrator to report all negligence in the facility. 2. Background checks will be done for all employees and they will be under supervision 3. The Administrator will monitor compliance with this correction. l'daily a per 4. The Tuff Memorial Home will be in compliance by June 28th, 2016. committee

F280 483.20(d) (3), 483.10(k) (2) Right to Participate Planning Care

monthe 1. Resident care plans will be updated every 90 days as required by law. The Tuff Memorial Home will train employees on the importance of charting.

RI was updated to trainde dentrie & oral cases anditary alle charets/Poc to have proper verision/update

audit why of monthly until 6/20/16 1st mits 2. The Director of Nursing and Administrator will monitor compliance with this correction. 3. The Tuff Memorial Home will be in compliance by June 28th, 2016. F282 483.20(5) (3) (ii) Services by Qualified Persons/Per Care Plan andit interven DON = 1. Staff will be trained on the correct procedure and the importance of following care plans. brushed and/or cleansed with morning and evening cares in accordance with the care plan. NSg mtg trained audits 6/2 46/6 Vechan. 3. Staff will be trained on the importance of documenting the effectiveness following 4. The Director of Nursing will monitor compliance with this correction. and it while report to mon 5. The Tuff Memorial Home will be in compliance by June 28th, 2016. R48 chant- audited + checked = report to \$A 6/20/16 QA not green F309 483.25 Provide Care/Services for Highest Well Being 1. The Hospice provider will be contacted and asked for a monthly schedule for their visits. 2. Per the Tuff Memorial Hospice Policy, the Tuff Memorial Home will remain the primary caregivers and the Hospice staff will be used in addition. Hospice provided 3. The Administrator and Director of Nursing will monitor compliance with this correction. Don-check for mo, 4. The Tuff Memorial Home will be in compliance by June 28th, 2016. Schedule + oe 6/20/16 Check for implement. F312 483.25(a) (3) ADL Care Provided for Dependent Residents 1. Staff will be trained on the correct procedure and importance of following all care plans. 2. Oral cares will be completed as stated by the resident's care plan. Ensure R28, R34, R2C followed up3. , The Director of Nursing will monitor compliance with this correction. Followice Card. The Tuff Memorial Home will be in compliance by June 28th, 2016. have been porid 2 staff 6 bs. Sleep $\frac{1}{1.05}$ Staff will be trained on the importance of documenting behaviors and non-pharmacological interventions attempted prior to the advised Sleep Struction of a PRN anti-FWService date Sleep Struction of a PRN anti-FWService date Conductance 2. The staff will also be trained on the importance of documenting the effectiveness of an Rule antidepressant medication. Chg. Chart for hela visoral documentation random and 3. The Director of Nursing will monitor compliance with this serve is a server of the server is a server of the server is the ort to QA for CNAS 5-24-16 and and 3. The Director of Nursing will monitor compliance with this correction. New York why X4 4. The Tuff Memorial Home will be in compliance to I $n_{f} \times 4$. The Tuff Memorial Home will be in compliance by June 28th, 2016. $n_{f} \times 4$. The Tuff Memorial Home will be in compliance by June 28th, 2016. F428 483.60(c) Drug Regimen Review, Report Irregular, Act On reviewel R48 = pha 1. The consulting pharmacist will be trained on the importance of informing the Director of Nursing or Administrator of the lack of documentation regarding the resident. 2. The Director of Nursing will monitor compliance with this correction. 3. The Tuff Memorial Home will be in compliance by June 28th, 2016. RECEIVED F441 483.65 Infection Control, Prevent Spread, Linens R46 065. for PropertyUN 1 5 2016 1. The staff will be trained on the proper hand hygiene after catheter cares. Manestoa Department of Health 2. Staff will wash their hands after any catheter handling. Marchall 3. Proper hand washing technique will be retrained to employees. 4. The Director of Nursing will monitor compliance with this correction. Conduct 665. 3 cares, including Catheter rise + audit why XH = Then monthly report to QA. DON- Chg MS. 2

5. The Tuff Memorial Home will be in compliance by June 28th, 2016. a dm - Check We 5. The Tutt Memorial Home will be in company of the Company of the Second State of the Second State of the Second State of the Second State of RIR28 1. The staff will be trained to identify when a wheelchair is needing an upgrade. Conduct RIR28 2. The staff will report this issue to the Director of Nursing or Administrator. We where the staff Memorial Home will be in compliance by June 28th, 2016. Chech Wichair for 2002 MNS

- 2302 MN State Statute 144.6503 Alzheimer's disease or Related Disorder Train
 - 1. The staff will receive training on Alzheimer's disease and proper documentation will be kept following the completion of this training.
 - 2. The Alzheimer's disease information will be added to the Applications Agreement and **Resident's Handbook**
 - 3. The Quality Assurance Committee will monitor compliance with this correction.
 - 4. The Tuff Memorial Home will be in compliance by June 21st, 2016.

2565 MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use

- 1. The staff will receive training on following resident care plans.
- 2. The Director of Nursing will monitor compliance with this correction.
- 3. The Tuff Memorial Home will be in compliance by June 21st, 2016.

2570 MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision

- 1. The staff will receive training on the timeliness of care plan revisions. The current policy will be reviewed with all employees.
- 2. The Director of Nursing and Quality Assurance Team will monitor compliance with this correction.
- 3. The Tuff Memorial Home will be in compliance by June 21st, 2016.

2830 MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General

- 1. The Hospice provider will be contacted to ensure services are coordinated with the facility. A monthly schedule for their visits will be requested.
- 2. Per the Tuff Memorial Hospice Policy, the Tuff Memorial Home will remain the primary caregivers and the Hospice staff will provide additional support.
- 3. The Administrator and Director of Nursing will monitor compliance with this correction.
- 4. The Tuff Memorial Home will be in compliance by June 21st, 2016.

2920 MN Rule 4658.0525 Subp. 6 Rehab – ADLs

- 1. Staff will be trained on the correct procedure and the importance of following care plans.
- 2. Oral cares will be completed as the care plan states. Resident's teeth and mouth will be brushed and/or cleansed with morning and evening cares in accordance with the care plan.
- 3. The Director of Nursing will monitor compliance with this correction.
- 4. The Tuff Memorial Home will be in compliance by June 21st, 2016.

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JUN 15 2016

21390 MN Rule 4658.0800 Subp 4 A-1 Infection Control

- 1. Director of Nursing will review policies and procedures to ensure proper infection control techniques are the most current methods.
- 2. The staff will be trained on the proper hand hygiene after catheter cares.
- 3. Staff will wash their hands after any catheter handling.
- 4. Proper hand washing technique will be retrained to employees.
- 5. The Director of Nursing will monitor compliance with this correction.
- 6. The Tuff Memorial Home will be in compliance by June 21st, 2016.

21530 MN Rule 4658.1310 A.B.C. Drug Regimen Review

- 1. Staff will be trained on the importance of documenting behaviors and nonpharmacological interventions attempted prior to the administration of a PRN antianxiety medication.
- 2. Staff will attempt non-pharmacological interventions prior to the administration of PRN anti-anxiety medication.
- 3. The staff will also be trained on the importance of documenting the effectiveness of an antidepressant medication in the event one is used as well as when non-pharmacological interventions are attempted.
- 4. We will consult with the Pharmacist regarding the need to review the drug regimen of each resident monthly.
- 5. The Director of Nursing will monitor compliance with this correction.
- 6. The Tuff Memorial Home will be in compliance by June 21st, 2016.

21540 MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring

- 1. The Administrator, Director of Nursing, and Consulting Pharmacist will review and revise policies and procedures for proper monitoring of medication usage.
- 2. The Director of Nursing will monitor compliance with this correction.
- 3. The Tuff Memorial Home will be in compliance by June 21st, 2016.

21685 MN Rule 4658.1415 Subp 2 Plant Housekeeping, Operation, & Maintenance

- 1. The staff will be trained to identify when a wheelchair is needing an upgrade.
- 2. The staff will report this issue to the Director of Nursing or Administrator.
- 3. The Administrator and Director of Nursing will monitor compliance with this correction.
- 4. The Tuff Memorial Home will be in compliance by June 21st, 2016.

21910 MN St. Statute 144.651 Subd. 25 Patients & Residents of HC Fac. Bill of Rights

- 1. We will inform the resident's their legal representatives of the statute requiring a max of \$50 in their resident trust account.
- 2. Any resident with personal funds over \$50 in their trust account will have the excess amount sent to their legal representative or put in their personal bank account based on situation.
- 3. Quarterly statements will be sent out to the resident or his or her legal representative.
- 4. The Administrator and Accountant will monitor compliance with this correction.
- 5. The Tuff Memorial Home will be in compliance by June 21st, 2016.

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JUN 1 5 2016

21980 MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults

- 1. Staff will be trained on the importance of reporting of all neglect/abuse situations to the administrator and State Agencies immediately in accordance to State law.
- 2. The Director of Nursing and Administrator will monitor compliance with this correction.
- 3. The Tuff Memorial Home will be in compliance by June 21st, 2016

21995 MN St. Statute 626.557 Subd. 4a Reporting Maltreatment of Vulnerable Adults

1. Staff will be trained on the importance of reporting all injuries of unknown origin and allegations of abuse to the administrator and State Agencies immediately in accordance to State law.

.

- 2. The Administrator, Director of Nursing, and Quality Assurance team will monitor compliance with this correction.
- 3. The Tuff Memorial Home will be in compliance by June 21^{st} , 2016.

RECEIVED

JUN 1 5 2016

Manestoa Department of Health Marshall

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		(X3)	DATE SURVEY
		245548	B. WING			05/19/2016
1. A.	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 505 EAST 4TH STREET HILLS, MN 56138	, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TÁG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATI	(X5) COMPLETIO DATE
F 000	INITIAL COMMEN	ГS	F 000		· · ·	
	as your allegation of Department's acce	of correction (POC) will serve of compliance upon the ptance. Your signature at the age of the CMS-2567 form will tion of compliance.				
E 160	revisit of your facilit validate that substa regulations has bee your verification.	acceptable POC an on-site y may be conducted to intial compliance with the en attained in accordance with	F 456			
SS=E	PERSONAL FUND Upon written autho facility must hold, s account for the per	CILITY MANAGEMENT OF S rization of a resident, the afeguard, manage, and sonal funds of the resident acility, as specified in	F 159			
	paragraphs (c)(3)-(The facility must de funds in excess of account (or accoun the facility's operati all interest earned of account. (In pooled					
	funds that do not ex	aintain a resident's personal ceed \$50 in a non-interest terest-bearing account, or				
	that assures a full a accounting, accord	stablish and maintain a system ind complete and separate ng to generally accepted is, of each resident's personal				
BORATOR	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN		cting Administra	alar	(X6) DATE
her safegua lowing the	ards provide sufficient pro date of survey whether o g the date these docume	an asterisk (*) denotes a deficiency whi tection to the patients, (See Instruction r not a plan of correction is provided. F nts are made available to the facility. If	ch the institu s.) Except fo or nursing ho	tion may be excused from corre or nursing homes, the findings so omes, the above findings and pl	ecting providing it is stated above are dis ans of correction are	closable 90 days e disclosable 14

and the second second

		AND HUMAN SERVICES & MEDICAID SERVICES	FORM APPROV OMB NO. 0938-03				
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	e survey Ipleted	
		245548	B. WING	,	05/19/2016		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 EAST 4TH STREET			
TUFF ME	EMORIAL HOME			HILLS, MN 56138			
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 159	Continued From pa	ae 2	F 15	9			
	statement of money	-					
- -	account was verifier receptionist (R)-B.	p.m. R46's personal fund d and reviewed with facility It showed a balance of \$50.00 s or credits were noted on the		· · ·			
	stated she was in cl accounts and maint verified all residents Account Form allow their personal funds confirmed that no in being maintained at provide a statement representative if the account during the r unaware the facility bearing accounts fo balances of \$50 or g related to quarterly all residents/respon	During interview on 5/17/16, at 3:26 p.m. R-B stated she was in charge of resident trust accounts and maintaining the records. R-B verified all residents sign a Resident Fund Account Form allowing the facility to maintain heir personal funds account. She further confirmed that no interest bearing accounts were being maintained at the facility and would only provide a statement to the resident and/or the epresentative if there had been activity in the account during the month. R-B stated she was inaware the facility was to provide interest bearing accounts for residents with personal fund balances of \$50 or greater and the requirement elated to quarterly personal fund statements to ill residents/responsible parties. Sixteen esidents (R46, R2, R16, R38, R1, R40, R41, R3,					
F 225 SS=D	requested but not pr 483.13(c)(1)(ii)-(iii),	(c)(2) - (4) 'ORT	F 22	5			
	been found guilty of mistreating resident	employ individuals who have abusing, neglecting, or s by a court of law; or have d into the State nurse aide		· · · · · · · · · · · · · · · · · · ·			

Facility ID: 00576

If continuation sheet Page 3 of 43

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		LE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245548	B. WING	•	· · · · · · · · · · · · · · · · · · ·	05/ [,]	19/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	EMORIAL HOME			5	05 EAST 4TH STREET		
				ŀ	IILLS, MN 56138		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	registry concerning of residents or misa and report any know court of law against indicate unfitness for other facility staff to or licensing authorit The facility must en involving mistreatme including injuries of misappropriation of immediately to the a to other officials in a through established State survey and ce The facility must ha violations are thorous prevent further pote investigation is in pr The results of all inv to the administrator representative and the with State law (inclu- certification agency) incident, and if the a appropriate correcti This REQUIREMEN by: Based on interview facility failed to thoro immediately report i and/or allegations o	abuse, neglect, mistreatment appropriation of their property; vledge it has of actions by a an employee, which would or service as a nurse aide or the State nurse aide registry ies. sure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law procedures (including to the ertification agency). ve evidence that all alleged ughly investigated, and must ntial abuse while the ogress.	F 2	225			

		AND HUMAN SERVICES				FOR): 06/17/2016 MAPPROVED
	CONTRACT CONTRACTICA TECONTRACT CONTRACTACT CONTRACTACTICACTICA TECONTRACTACTICA TECONTRACTACTICONTRAC	& MEDICAID SERVICES			CONSTRUCTION		<u>). 0938-0391</u> TE SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:	1				MPLETED
2		245548	B. WING			0	5/19/2016
NAME OF I	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	I	STR	REET ADDRESS, CITY, STATE, ZIP CODE		/10/2010
	EMORIAL HOME		,	505	EAST 4TH STREET		
				HIL	LS, MN 56138		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 225	incidents (R28 & R2	-	F 2	225	· · · · · · · · · · · · · · · · · · ·		
	orders dated 4/7/16	according to the physician , which included: dementia, psychosis, anxiety and e.		·			
	assessment, dated Brief Interview for M 3, which indicated s The MDS further ide	imum Data Set (MDS) 3/22/16, identified R28 had a lental Status (BIMS) score of evere cognitive impairment. entified R28 required e of one staff with all activities s).					
	noted on 12/25/15, injury. The details o incident report dated indicated R28's alar staff and when staff found lying on the fl side in front of her r located at the edge table in R28's room. have a "pool of bloo Documentation indic her hair and running R28 also had a larg region that measure cm with a laceration skin tear was noted measuring 9 cm by	cility incident reports it was R28 had a fall with significant f the fall documented on the d 12/25/15, at 10:04 p.m. m was heard sounding by entered the room, R28 was oor in her room on her right ecliner. R28's head was of the recliner by the end R28 was observed by staff to d" under her head. cated R28 had blood noted in g down the side of her face. e lump on her right temple ed 4.5 centimeters (cm) by 7.5 in the center of the lump. A on the top of her right hand 3 cm, with the skin rolled amount of blood coming from					
		entation further identified R28					
ORM CMS-25	37(02-99) Previous Versions	Obsolete Event ID: QFK011	L i	Facility	ID: 00576 If cont	inuation shee	et Page 5 of 43

1

		AND HUMAN SERVICES & MEDICAID SERVICES			:	FC	NO. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION G	(X3)	DATE SURVEY COMPLETED
		245548	B. WING	÷			05/19/2016
NAME OF	PROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
TUFF ME	EMORIAL HOME				505 EAST 4TH STREET HILLS, MN 56138		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 225	had a commode be alarm was sounding noted on the floor a running down her le pad) was also noted and it was soiled. R28 was transporte via personal autome R28 was transporte 12/26/15, at 1:15 a. return to facility, phy continue current me as needed for five (provider. When interviewed of director of nursing (not reported to the 3 incident. R48 had diagnoses disease, dementia v fibromyalgia, and os physician's orders of R48's 14-day Minim assessment dated 4 Brief Interview for M 3, which indicated s The MDS further ide extensive assistance of daily living (ADL's During review of R4 noted on 3/17/16, R with significant injur identified on the inc	side her bed and her personal g. There was a pool of urine nd R28 had incontinent stool eg. R28's brief (incontinent d lying on the floor by her feet d to the hospital for treatment obile with a family member. d back to the facility on m. via ambulance. Upon ysician orders included: edications, place ice on lump 5) days, and follow-up with her on 5/19/16, at 9:36 a.m. the DON) verified the facility had SA nor investigated this that included: Alzheimer's with behavioral disturbance, steoarthritis per the signed lated 4/12/16. hum Data Set (MDS) 4/3/16, identified R48 had a flental Status (BIMS) score of severe cognitive impairment. entified R48 required te of one staff with all activities	F	228	5		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SUI COMPLET NAME OF PROVIDER OR SUPPLIER 245548 B. WING 05/19/2 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 05/19/2 TUFF MEMORIAL HOME SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION			AND HUMAN SERVICES				FORM	06/17/2016 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER Iteration STREET ADDRESS, CITY, STATE, ZIP CODE TUFF MEMORIAL HOME STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID PRETX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX PROVIDERS PLAN OF CORRECTION (EACH OBFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX PROVIDERS PLAN OF CORRECTION (EACH OBFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX F 225 Continued From page 6 3/17/16, at 11:55 a.m. Staff heard R48 call for help and upon entering the room observed R48 lying on left side holding her right buttock thigh area. Documentation indicated R48 verbalized excruciating pain with facial grimacing when bending her right knee. R48 was transferred to the hospital. The subsequent progress note dated 3/18/16, at 2:48 a.m. indicated R48 had been admitted to the hospital. The subsequent progress note dated 3/18/16, at 11:30 a.m. indicated a CT scan identified R48 had a fracture to the right pelvis. R48 returned to the facility on 3/21/16. When interviewed on 5/18/16, at 3:30 p.m. the DON confirmed the 3/17/16 fall resulting in pelvic fracture was not reported as it was determined	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1				
TUFF MEMORIAL HOME 505 EAST 4TH STREET HILLS, MN 56138 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH ODEFICIENCY MIST 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) COM F 225 Continued From page 6 3/17/16, at 11:55 a.m. Staff heard R48 call for help and upon entering the room observed R48 lying on left side holding her right buttock thigh area. Documentation indicated R48 verbalized excruciating pain with facial grimacing when bending her right knee. R48 was transferred to the hospital on 3/18/16, at 12:48 a.m. via ambulance for evaluation and treatment. F 225 Review of R48's progress note dated 3/18/16, at 2:48 a.m. indicated R48 had been admitted to the hospital. The subsequent progress note dated 3/18/16, at 11:30 a.m. indicated a CT scan identified R48 had a fracture to the right pelvis. R48 returned to the facility on 3/21/16. When interviewed on 5/18/16, at 3:30 p.m. the DON confirmed the 3/18/16 fail resulting in pelvic fracture was not reported as it was determined			245548	B. WING	i		05/	19/2016
TUFF MEMORIAL HOME HILLS, MN 56138 (X4) ID PREFIX 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 DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) OV F 225 Continued From page 6 3/17/16, at 11:55 a.m. Staff heard R48 call for help and upon entering the room observed R48 lying on left side holding her right buttock thigh area. Documentation indicated R48 verbalized excruciating pain with facial grimacing when bending her right knee. R48 was transferred to the hospital on 3/18/16, at 12:48 a.m. via ambulance for evaluation and treatment. F 225 Review of R48's progress note dated 3/18/16, at 2:48 a.m. indicated R48 had been admitted to the hospital. The subsequent progress note dated 3/18/16, at 11:30 a.m. indicated a CT scan identified R48 had a fracture to the right pelvis. R48 returned to the facility on 3/21/16. When interviewed on 5/18/16, at 3:30 p.m. the DON confirmed the 3/17/16 fall resulting in pelvic fracture was not reported as it was determined	NAME OF F	PROVIDER OR SUPPLIER						
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From Page 6 Continued From page 6 F 225 F 225 Continued From page 6 F 225 F 225 F 225 Alter and upon entering the room observed R48 lying on left side holding her right buttock thigh area. Documentation indicated R48 verbalized excruciating pain with facial grimacing when bending her right knee. R48 was transferred to the hospital on 3/18/16, at 12:48 a.m. via ambulance for evaluation and treatment. F Review of R48's progress note dated 3/18/16, at 2:48 a.m. indicated R48 had been admitted to the hospital. The subsequent progress note dated 3/18/16, at 11:30 a.m. incicated a CT scan identified R48 had a fracture to the right pelvis. R48 returned to the facility on 3/21/16. When interviewed on 5/18/16, at 3:30 p.m. the DON confirmed the 3/17/16 fall resulting in pelvic fracture was not reported as it was determined	TUFF ME	EMORIAL HOME						
3/17/16, at 11:55 a.m. Staff heard R48 call for help and upon entering the room observed R48 lying on left side holding her right buttock thigh area. Documentation indicated R48 verbalized excruciating pain with facial grimacing when bending her right knee. R48 was transferred to the hospital on 3/18/16, at 12:48 a.m. via ambulance for evaluation and treatment. Review of R48's progress note dated 3/18/16, at 2:48 a.m. indicated R48 had been admitted to the hospital. The subsequent progress note dated 3/18/16, at 11:30 a.m. indicated a CT scan identified R48 had a fracture to the right pelvis. R48 returned to the facility on 3/21/16. When interviewed on 5/18/16, at 3:30 p.m. the DON confirmed the 3/17/16 fall resulting in pelvic fracture was not reported as it was determined	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	(X5) COMPLETION DATE
 confirmed the fall was unwitnessed and R48 was unable to tell staff the circumstances related to the fall. The incident had not been reported immediately as required by facility policy. The facility Vulnerable Protection Plan revised 7/1/15, included under definitions the following: (12.) INJURIES OF UNKNOWN ORIGIN: An injury that meets both the following conditions: (1) If the source of injury was not observed by any person or the source of the injury could not be reasonably explained by the resident, AND, (2) if the injury or the location of the injury or the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time or the incidence of injuries over time. This includes an injury to a resident resulting in bruising, fractures, skin tears, lacerations, welts, etc. 	F 225	3/17/16, at 11:55 a. help and upon enter lying on left side ho area. Documentative excruciating pain with bending her right krithe hospital on 3/18 ambulance for evalue Review of R48's pro- 2:48 a.m. indicated hospital. The subset 3/18/16, at 11:30 a. identified R48 had a R48 returned to the When interviewed of DON confirmed the fracture was not rep the care plan was be confirmed the fall with unable to tell staff the the fall. The inciden immediately as require The facility Vulneration 7/1/15, included und (12.) INJURIES OF injury that meets bo (1) If the source of ithe person or the source reasonably explained the injury is suspicited the injury or the location number of injuries of point in time or the ithe This includes an inju- bruising, fractures, suspicited the injury fractures, suspicited the injury fractures of the injury is suspicited the injury of the location in the of the injury of the location the injury of the location of the injury of the location the injury of the location of the injury of the location the injury of the location of the injury of the location the injury of the location of the injury of t	m. Staff heard R48 call for ring the room observed R48 Iding her right buttock thigh on indicated R48 verbalized ith facial grimacing when hee. R48 was transferred to 0/16, at 12:48 a.m. via uation and treatment. Ogress note dated 3/18/16, at R48 had been admitted to the equent progress note dated m. indicated a CT scan a fracture to the right pelvis. facility on 3/21/16. on 5/18/16, at 3:30 p.m. the 3/17/16 fall resulting in pelvic ported as it was determined eing followed. DON further as unwitnessed and R48 was ne circumstances related to t had not been reported uired by facility policy. ble Protection Plan revised der definitions the following: FUNKNOWN ORIGIN: An th the following conditions: njury was not observed by any e of the injury could not be ad by the resident, AND, (2) if ous because of the extent of ation of the injury or the observed at one particular incidence of injuries over time. ury to a resident resulting in	F 2	225			

Facility ID: 00576

If continuation sheet Page 7 of 43

		AND HUMAN SERVICES				FORM	06/17/2016 APPROVED 0938-0391
STATEMEN	TOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245548	B. WING			05/	19/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
TUFF MI	EMORIAL HOME				05 EAST 4TH STREET IILLS, MN 56138		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	Continued From pa	ge 7	F 2	225			
F 226 SS=D	possible from the til that the incident occ after discovery of the aware of a situation emergency, medica services should be should call 911 first immediately. The policy further in (A.) Staff is to notific concerning any obs abuse, neglect, invo- maltreatment/mistre or misappropriation administrator along occurrences withou resident/alleged vic 483.13(c) DEVELO ABUSE/NEGLECT, The facility must de policies and proced mistreatment, negle and misappropriation This REQUIREMEN by: Based on interview facility failed to follo investigation and im allegations of abuse origin for 2 of 5 resi	eatment, unknown injury event of personal property with any patterns, trends or t interviewing the tim. P/IMPLMENT ETC POLICIES velop and implement written	F 2	26			

		AND HUMAN SERVICES				FORM	06/17/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		e survey Ipleted
		245548	B. WING			05/	19/2016
NAME OF F	PROVIDER OR SUPPLIER	<u></u>			TREET ADDRESS, CITY, STATE, ZIP CODE		
TUFF ME	EMORIAL HOME				05 EAST 4TH STREET HLLS, MN 56138		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 226	the intial backgrour employees for 1 of (NA)-A) documents background.	ge 8 ad screening of new 5 employee (nursing assistant s reviewed and who required a	F 2	226			
	Protection Plan rev following: (12.) INJURIES OI injury that meets bo (1) If the source of person or the source reasonably explained the injury is suspici- the injury or the loc number of injuries of point in time or the This includes an injuries of	mplement their Vulnerable ised 7/1/15, which included the F UNKNOWN ORIGIN: An oth the following conditions: injury was not observed by any ce of the injury could not be ed by the resident, AND, (2) if ous because of the extent of ation of the injury or the observed at one particular incidence of injuries over time. ury to a resident resulting in skin tears, lacerations, welts,				·	
	possible from the ti that the incident oc after discovery of th aware of a situation emergency, medica services should be should call 911 first immediately.	Y: means as soon as me of the initial knowledge curred, has been received or ne incident. If staff becomes n or incident where police, al services or protective involved ASAP, the facility and then report to the MDH			· · · · · · · · · · · · · · · · · · ·		
FORM CMS-24	(A.) Staff is to notif concerning any obs abuse, neglect, inv maltreatment/mistr	y Administrator IMMEDIATELY servations or witnessing of oluntary seclusion, eatment, unknown injury event of personal property	1	Fa	cility ID: 00576 If conti	nuation shee	t Page 9 of 43

		AND HUMAN SERVICES			:		FORM	: 06/17/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION 3		X3) DAT	E SURVEY IPLETED
		245548	B. WING				05/	19/2016
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
TUFF ME	EMORIAL HOME				505 EAST 4TH STREET HILLS, MN 56138			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD B		(X5) COMPLETION DATE
F 226	administrator along occurrences withou resident/alleged vic In addition, under th	with any patterns, trends or tinterviewing the	F 2	26	}			
	Minnesota Departm Administrator on all	udies are submitted to the lent of Human Services by the employees at the Tuff suant to Minnesota Statutes,						
	investigation, immed administrator and to had an injury of unk diagnoses according dated 4/7/16, which	their policy related to the diate reporting to the o the State agency when R28 nown origin. R28 had g to the physician orders included: dementia, major sis, anxiety and Alzheimer's						
	assessment, dated Brief Interview for M 3 which indicated se The MDS further ide	mum Data Set (MDS) 3/22/16, identified R28 had a lental Status (BIMS) score of evere cognitive impairment. entified R28 required e of one staff with all activities s).						
	noted on 12/25/15, I injury. The details of incident report, date indicated R28's alar staff and when staff found lying on the flo side in front of her re located at the edge	ility incident reports it was R28 had a fall with significant f the fall documented on the d 12/25/15, at 10:04 p.m. m was heard sounding by entered the room, R28 was bor in her room on her right ecliner. R28's head was of the recliner by the end R28 was observed by staff to						

Facility ID: 00576

If continuation sheet Page 10 of 43

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245548	B. WING			05/	19/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 05 EAST 4TH STREET	"	
TUFF MI	EMORIAL HOME				ILLS, MN 56138		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Prefix Tag		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	have a "pool of bloc Documentation indi her hair and running R28 also had a larg region that measure cm with a laceration skin tear was noted measuring 9 cm by back and a "large" a the skin tear. The incident docum had a commode be alarm was sounding noted on the floor a running down her le pad) was also noted and it was soiled. R28 was transporte via personal automo R28 was transporte 12/26/15, at 1:15 a. return to facility, phy continue current me as needed for five (provider. When interviewed of director of nursing (not reported to the s this incident. The facility did not in Adult policy which re- immediate notification	-	F 2:	26			

Facility ID: 00576

If continuation sheet Page 11 of 43

		AND HUMAN SERVICES					RINTED: 0 FORMAF MB NO. 09	PROVED
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONS	STRUCTION		(X3) DATE S COMPLE	
		245548	B. WING			_	05/19/	2016
NAME OF I	PROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STA	TE, ZIP CODE		
TUFF ME	EMORIAL HOME				T 4TH STREET MN 56138			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN (EACH CORRECTIVE ROSS-REFERENCED DEFIC	ACTION SHOULD	BE C	(X5) OMPLETION DATE
F 226	R48 had diagnoses disease, dementia v fibromyalgia, and or physician's orders of R48's 14-day Minim assessment, dated Brief Interview for M 3, which indicated s The MDS further idd extensive assistance of daily living (ADL's During review of R4 noted on 3/17/16, R with significant injur identified on the inc 1:35 a.m. indicated 3/17/16, at 11:55 a.f help and upon enter lying on left side hol area. Documentatic excruciating pain wi bending her right kr the hospital on 3/18 ambulance for evalue Review of R48's pro 2:48 a.m. indicated hospital. The subse 3/18/16, at 11:30 a.r identified R48 had a R48 returned to the When interviewed of DON confirmed the fracture was not rep	 that included: Alzheimer's with behavioral disturbance, steoarthritis per the signed lated 4/12/16. num Data Set (MDS) 4/3/16, identified R48 had a Mental Status (BIMS) score of severe cognitive impairment. entified R48 required se of one staff with all activities (BIMS) score of covere cognitive impairment. 8's incident reports it was taken had an unwitnessed fall y. The details of the fall ident report dated 3/18/16, at the incident occurred on m. Staff heard R48 call for ring the room observed R48 Iding her right buttock thigh on indicated R48 verbalized th facial grimacing when nee. R48 was transferred to /16, at 12:48 a.m. via uation and treatment. ogress note dated 3/18/16, at R48 had been admitted to the equent progress note dated m. indicated a CT scan a fracture to the right pelvis. 	F2	226				
FORM CMS-25	confirmed the fall wa	as unwitnessed and R48 was Obsolete Event ID: QFK01		Facility (D: 0)	0576	If continuatio	on sheet Pag	e 12 of 43

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245548	B. WING			05/	19/2016
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
TUFF ME	MORIAL HOME				ILLS, MN 56138		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226		ge 12 ne circumstances related to	F 22	26			
	employment file lac check initiated on h						
	pay period indicated	ng schedules for the current I NA-A was working on the t resident care at least one		:			
	10:00 a.m. the adm indicated he was th initiating backgroun and verified NA-A d check on file. The Minnesota Departm NETStudy 2.0 that	5/19/16, at approximately inistrator in training (AIT) e responsible party for d studies at the present time, id not have a background AIT presented a copy of a ent of Human Services was initiated on 5/19/16. The					
F 280 SS=D	by a previous employed them at the time of 483.20(d)(3), 483.1		F 28	80			
	incompetent or othe incapacitated under	the laws of the State, to ng care and treatment or					
	within 7 days after t comprehensive ass interdisciplinary tea physician, a register	are plan must be developed he completion of the essment; prepared by an m, that includes the attending red nurse with responsibility I other appropriate staff in					

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

Facility ID: 00576

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		AND HUMAN SERVICES				FORM	: 06/17/2016 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245548	B. WING	÷		05/	19/2016
NAME OF I	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
TUFF ME	EMORIAL HOME				505 EAST 4TH STREET HILLS, MN 56138		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	I IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	BE	(X5) COMPLETION DATE
F 280	Continued From par disciplines as detern and, to the extent p the resident, the resi- legal representative and revised by a tea- each assessment. This REQUIREMEN- by: Based on observat review the facility far was updated with re- and oral cares for 1 for activities of daily Findings include: R1's quarterly Minin assessment dated 7 required total assist grooming. An oral/of did not trigger for R assessment. R1's care plan dated upper dentures and teeth and upper der assignment sheet a R1's Mouth/Throat/I Communication assis indicated R1 had tee poor condition and v assessment also ide	ge 13 mined by the resident's needs, racticable, the participation of sident's family or the resident's e; and periodically reviewed am of qualified persons after NT is not met as evidenced ion, interview and document iled to ensure the plan of care egard to the use of dentures of 3 residents (R1) reviewed living. hum Data Set (MDS) 12/21/15, indicated he ance of two staff for dental care area assessment 1 during the prior full MDS d 5/18/16, indicated R1 had staff were to brush his lower nture. R1's nursing assistant lso dated 5/18/16, indicated e brushed. Neck/Speech and ressment dated 7/20/15, eth in the lower gum line in wore upper dentures. The entified R1 had terminal	F		DEFICIENCY)		
	multiple sclerosis (M	IS).					

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		AND HUMAN SERVICES				M APPROV <u>). 0938-03</u>
	OF DEFICIENCIES, DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		TE SURVEY
		245548	B. WING		05	5/19/2016
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP		
TUFF ME	EMORIAL HOME			505 EAST 4TH STREET HILLS, MN 56138		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
F 280	Continued From pa	age 14	F 280		arran	
	nursing assistant (N cares for R1. NA-C dentures stating, "I them." NA-H, also cares indicated R1	on 5/18/16, at 8:32 a.m. NA) -G performed personal G indicated R1 no longer wore because he eats better without present in the room during had not worn the dentures 015 (5 months prior).			·	
	practical nurse (LPI usually wear his de weight and the den	5/17/16, at 1:25 p.m. licensed N)-A confirmed R1 did not ntures as he had lost so much tures were very loose. LPN-A vas not a concern for R1 as he erved at meals.				
	director of nursing (plan should have be that he was no long The Tuff Memorial I	Home Care Plan policy, last				
F 282 SS=E	be reviewed every §	dicated each care plan would 90 days as required by law. RVICES BY QUALIFIED ARE PLAN	F 282			
	must be provided by	led or arranged by the facility y qualified persons in ch resident's written plan of				
	by: Based on observat review the facility fa	NT is not met as evidenced ion, interview and document illed to ensure oral cares were ance with the care plan for 3 of			·	

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		AND HUMAN SERVICES				FORM	1 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION IG	(X3) DAT	TE SURVEY MPLETED
		245548	B. WING	3 <u> </u>		05	/19/2016
NAME OF I	PROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
	MORIAL HOME				505 EAST 4TH STREET		
					HILLS, MN 56138		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 282	4 residents (R26, R activities of daily livi failed to follow the of documentation of in as needed (PRN) A use for 1 of 5 reside unnecessary medic Findings include: R26's significant ch assessment dated a required extensive a grooming. The Car oral/dental status di R26's care plan last that R26 had Lewy assistance to place [dentures] at hour of cup. The care plan teeth should be brue The nursing assista 5/18/16, indicated F brushed. Morning cares were at 7:44 a.m. At 8:17 had completed mor cares were observe asked whether R26 completed, NA-H in stated she should h	28, R34) reviewed for ing. In addition, the facility care plan related to interventions attempted prior to itivan (anti-anxiety medication) ents (R48) reviewed for ations. ange in status MDS 4/19/16, indicated R26 assistance of two staff for re Area Assessment (CAA) for	, E	282			
	bathroom. Observa still had his denture not been soaked as	tion at this time revealed R26 s in his mouth and they had directed. NA-H indicated the bly been in all night as he					

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		AND HUMAN SERVICES				FORM	APPROVED
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION	(X3) DA1	TE SURVEY MPLETED
		245548	B. WING			05/	/19/2016
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
TUFF ME	EMORIAL HOME				505 EAST 4TH STREET HILLS, MN 56138		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION}	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	Continued From pa sometimes refused	-	F2	82			
	director of nursing (residents' teeth and	5/18/16, at 10:01 a.m. the DON) indicated that all mouth should be brushed h morning and evening cares the care plan.	- -				
	Checklist, last revie were to brush dentu brush and paste ad	Home Oral Competency wed 3/17/16 indicated staff ires or teeth using personal hering to the resident's routine e. Soak dentures at HS in ip.					
	in the plan of care. I to the physician ord	e dental care for R28 as stated R28 had diagnoses according ers dated 4/7/16, which major depression, psychosis, ier's disease.					
	R28 would be able f	an dated 3/29/16, identified to participate in oral cares on are plan identified staff would care supplies.					
	assessment dated 3	mum Data Set (MDS) 3/22/16, identified R28 assistance of one staff with all ng (ADL's).					
	at 8:06 a.m. nursing R28 out of bed. NA bedside commode a washing, dressing a toileting. At 8:18 a.r the commode into h	of morning cares on 5/19/16, assistant (NA)-B assisted -B transferred R28 onto a and assisted R28 with face nd perineal cares after n. NA-B transferred R28 from er wheelchair using a gait belt ombed R28's hair and asked					

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		AND HUMAN SERVICES			FORM	: 06/17/2016 APPROVED . 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	ECONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245548	B. WING		05/	19/2016		
NAME OF I	PROVIDER OR SUPPLIER	1	1	REET ADDRESS, CITY, STATE, ZIP CODE	•			
TUFF MEMORIAL HOME			505 EAST 4TH STREET HILLS, MN 56138					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE		
F 282	R28 whether she w NA-B was preparin if oral cares were g stated, "Oh, I gues breakfast. Do you t NA-B stated she w breakfast. NA-B fu supposed to set up encourage her to b When interviewed registered nurse (F be completed durin RN-C stated she w oral cares when ge morning to ensure and their mouths c Dental care was no to the plan of care. assessment dated which included: de congestive heart fa R34's active care p R34 at risk for nutr teeth and significan further identified R wheel, transfer, rep self independently. R34's quarterly Min assessment dated required extensive	vas ready to go to breakfast. Ig to exit the room when asked going to be completed. NA-B s I can do them after think I should do them now." ould do the oral cares after rther stated staff were b R28's oral supplies and brush her teeth. on 5/19/16, at 8:32 a.m. RN)-C stated oral cares should ng morning and bedtime cares. Yould expect staff to provide atting the residents up in the if they have dentures placed lean for breakfast. ot provided for R34 according According to the quarterly 4/19/16, R34 had diagnoses epression, anemia, anxiety, ailure and hypertension. blan dated 4/26/16, identified itional deficit related to loose nt weight loss. The care plan 28 was unable to bathe, dress, position, toilet, groom, and feed himum Data Set (MDS) 4/19/16, identified R34 assistance with all ADL's.	F 282					
	observed to assist a morning bath. N/	a.m. NA-E and NA-F were R34 with dressing as R34 had A-E and NA-F transferred R34 se of a mechanical lift. After						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-									
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		245548	B. WING			05/19/2016			
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE				
TUFF MEMORIAL HOME				505 EAST 4TH STREET HILLS, MN 56138					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		id Pref Tag		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION			
F 282	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F2	282					

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If continuation sheet Page 19 of 43

		AND HUMAN SERVICES				FORM	06/17/2016 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		LE CONSTRUCTION	X3) DATE SURVEY COMPLETED	
		245548	B. WING			05/19/2016	
NAME OF F	PROVIDER OR SUPPLIER		·		STREET ADDRESS, CITY, STATE, ZIP CODE		
TUFF ME	EMORIAL HOME		505 EAST 4TH STREET HILLS, MN 56138				
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL						(X5) COMPLETION DATE
F 282	Continued From pa looking for husband Start date of order- Review of R48's ca included: PRN Ativ wanting to go home within 15 minutes. T sewing blankets and before giving. Review of the electri (eMAR) revealed R Ativan 35 times from review of the reside record indicated doo behavior exhibited a attempted prior to a effectiveness follow documented 15 out When interviewed of licensed practical no PRN Ativan is only g interventions are no the interventions pri eMAR. LPN-A furth given the medicatio "comments" section behavior and interve administration.	ge 19 3 times within 15 minutes; 3/3/16. re plan last revised 5/2/16, an every 4 hours if agitated or a, looking for husband 3 times Try PRN wine, talking about d talking about gardening ronic administration record 48 was administered PRN n 3/6/16 - 5/14/16. Further nt's eMAR and electronic cumentation related to R48's and staff interventions dministration of Ativan, and ing administration were only of 35 times. on 5/19/16, at 8:20 a.m. urse (LPN)-A stated R48's given if non-pharmacological t effective. LPN-A confirmed or to use were listed on the ner stated when PRN Ativan is n nurse is to document in the a description of R48's entions attempted prior to on 5/18/16, at 2:21 p.m.	F 2		DEFICIENCY)		
	registered nurse (R care plan included s attempt prior to adm RN-B reviewed R48 surveyor and confir consistently docume	N)-B confirmed the eMAR and specific interventions to ninistering R48's PRN Ativan. I's PRN Ativan use with the					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					E CONSTRUCTION	(X3) DAT	E SURVEY
		245548	B. WING			05/	19/2016
NAME OF PF	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
TUFF MEN	MORIAL HOME				05 EAST 4TH STREET IILLS, MN 56138		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309 SS=D F 309 F 309 F 309 F F F F F F F	consistently docume PRN Ativan and wor this. When interviewed of director of nursing (expectation when give to document behattempted prior to a document effectiver of care. 483.25 PROVIDE C HIGHEST WELL BE Each resident must provide the necessa or maintain the high mental, and psychol accordance with the and plan of care. This REQUIREMEN by: Based on observati eview the facility fai coordinated with the residents (R1) review Findings include: R1's quarterly Minim	ned staff were also not enting the effectiveness of the uld expect charting to reflect in 5/19/16, at 9:45 a.m. the DON) confirmed the iving R48's PRN Ativan would aviors and interventions dministration, and to also ness as identified on the plan ARE/SERVICES FOR EING receive and the facility must iny care and services to attain est practicable physical, social well-being, in comprehensive assessment	F 2				
		ssistance in all activities of not able to be understood.					

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		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	06/17/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	4 ` ´		LE CONSTRUCTION		(X3) DATE	E SURVEY PLETED
		245548	B. WING	;			05/ [,]	19/2016
NAME OF I	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CO	DE		
	MORIAL HOME				505 EAST 4TH STREET			
					HILLS, MN 56138			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD	BE	(X5) COMPLETION DATE
F 309	R1's care plan date received hospice set together with hospic resident's needs, co care plan further id health aide visits with R1's hospice plan of he received skilled weekly and as need two times per mont weekly and chaplai During observation was observed lying boots on, and show distress. R1 was u verbally. During observation nursing assistant (N performing cares w communicate and r staff to get out of be complete morning of discomfort were ob During interview on indicated he though coming to spend tir communicated duri nurse during report there was a routine for R1. During interview on practical nurse (LPI	d 5/18/16, identified that R1 ervices and staff were to work ce staff to communicate oncerns and comments. The entified R1 received home	F	309				
EORM CMS-25	visits and used hav	e hospice staff provide bed Obsolete Event ID: QFKO1	1	Fa	acility ID: 00576 If con	ntinuatio	on sheet I	Page 22 of 43

		AND HUMAN SERVICES				FORM	APPROVED			
I		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA					0938-0391			
	FOF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED			
		245548	B. WING_			05/	19/2016			
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE					
TUFF ME	EMORIAL HOME			505 EAST 4TH STREET HILLS, MN 56138						
(X4) ID PREFIX TAG	ÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	:	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 309	Continued From pa baths for R1 and pe beneficial for him; h only assist with feed LPN-A indicated the lot of changes recent they come, they corr with our business." During interview on registered nurse (Ri agency used to provide this inform During interview on medication aide (TM unsure what hospice indicated she worke TMA-A indicated she communication regaunless it involved m During interview on hospice RN-F indicates social services and findings. RN-F verifi with feeding and the facility staff. RN-F in hospice staff to door	ge 22 erform skin care which were owever, but now hospice staff ling R1 due to weight loss. hospice agency had made a ntly and indicated "I guess if ne and if they don't, we go on 5/17/16, at 1:33 a.m. N)-E indicated the hospice vide their schedule of visits; the agency no longer ation. 5/18/16, at 7:41 a.m. trained IA)-A indicated she was a was providing for R1 and d full-time at the facility. e did not receive any arding the hospice services,	F 30	99						
	director of nursing (I provide a calendar v however, no longer they usually commu services designee (S	n 5/18/16, at 10:01 a.m. the DON) confirmed hospice used vith their scheduled visits, does. The DON indicated nicated with the social SSD) and talked to the RN e to provide services.								

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		AND HUMAN SERVICES				FORM	: 06/17/2016 1 APPROVED . 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	TIPLE CONSTRU	(X3) DA1	re Survey Mpleted		
		245548	B. WING			05/19/2016		
NAME OF F	PROVIDER OR SUPPLIER				DRESS, CITY, STATE, ZIP CODE			
TUFF ME	MORIAL HOME			505 EAST 4 HILLS, MN	TH STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X EA	PROVIDER'S PLAN OF CORREC ACH CORRECTIVE ACTION SHO SS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 309	Continued From pa	ge 23	F3	09				
	indicated the hospid the visit to report and documentation on h sure why they no lo stating that was hel staff to coordinate of hospice visits vary a schedule book that During interview on indicated that hospic calendars and did n anymore. RN-B furt staff did not come p	5/18/16, at 9:55 a.m. the SSD ce nurse visited with her after by problems and left her her desk. The SSD was not nger provided a calendar, pful communication for facility cares. The SSD indicated the and she was unaware of any hospice visits are recorded. 5/18/16, at 10:06 a.m. RN-B ce had quit providing tot write down there visits her stated that since hospice prior to R1 getting up for the						
F 312 SS=E	When interviewed of hospice RN-F indica hospice providing a cares for R1, "I will is no schedule. We The Hospice Policy last updated 3/29/16 Home staff remain the hospice staff are us support the resident emotional end of life 483.25(a)(3) ADL C DEPENDENT RESI A resident who is un daily living receives	ARE PROVIDED FOR	F 3	.12				
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: QFKO1	ł	Facility ID: 0057	6 If contin	uation sheet	Page 24 of 43	

		AND HUMAN SERVICES				FORM	APPROVED		
	RS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MH	TIP	LE CONSTRUCTION	1	. 0938-0391 E SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	IPLETED					
		245548	B. WING			05/19/2016			
NAME OF	PROVIDER OR SUPPLIER		I	STREET ADDRESS, CITY, STATE, ZIP CODE					
	EMORIAL HOME				505 EAST 4TH STREET				
				ł	HILLS, MN 56138				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 312	2 Continued From page 24		F 3	12		1			
		IT is not met as evidenced							
	review the facility fa completed for 4 of 4	ion, interview and document iled to ensure oral cares were I residents (R28, R34, R26, tivities of daily living (ADL).							
	Findings include:								
	required extensive a had diagnoses acco dated 4/7/16, which	e dental care for R28, who assistance with all ADL's. R28 ording to the physician orders included: dementia, major sis, anxiety and Alzheimer's							
	R28 would be able t	an dated 3/29/16, identified o participate in oral cares on are plan identified staff would care supplies.							
	assessment dated 3	mum Data Set (MDS) 3/22/16, identified R28 assistance of one staff with all ng (ADL's).	·						
	at 8:06 a.m. nursing R28 out of bed. NA bedside commode a washing, dressing a toileting. At 8:18 a.r the commode into h and walker. NA-B co R28 whether she wa NA-B was preparing	of morning cares on 5/19/16, assistant (NA)-B assisted -B transferred R28 onto a and assisted R28 with face nd perineal cares after n. NA-B transferred R28 from er wheelchair using a gait belt ombed R28's hair and asked as ready to go to breakfast. to exit the room when asked sing to be completed. NA-B							

Facility ID: 00576

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		AND HUMAN SERVICES				FORM	: 06/17/2016 1 APPROVED). 0938-0391		
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED		
		245548	B. WING	€		05/19/2016			
NAME OF I	PROVIDER OR SUPPLIER	•	•		STREET ADDRESS, CITY, STATE, ZIP CODE	·			
TUFF MEMORIAL HOME					505 EAST 4TH STREET HILLS, MN 56138				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE		
F 312	breakfast. Do you th NA-B stated she wo breakfast. NA-B fur supposed to set up encourage her to be When interviewed of registered nurse (R be completed durin RN-C stated she wo oral cares when get morning to ensure if and their mouths cle Dental care was no required extensive a According to the qu 4/19/16, R34 had di depression, anemia failure and hyperter R34's active care pl R34 at risk for nutrit teeth and significan further identified R2 wheel, transfer, rep self independently. R34's quarterly Min assessment dated required extensive a On 5/19/16 at 6:36 observed to assist F a morning bath. NA into bed with the us they dressed R34, f	s I can do them after hink I should do them now." build do the oral cares after ther stated staff were R28's oral supplies and rush her teeth. on 5/19/16, at 8:32 a.m. N)-C stated oral cares should g morning and bedtime cares. ould expect staff to provide titing the residents up in the if they have dentures placed ean for breakfast. t provided for R34, who assistance with ADL's. harterly assessment dated iagnoses which included: a, anxiety, congestive heart nsion. lan dated 4/26/16, identified tional deficit related to loose t weight loss. The care plan 28 was unable to bathe, dress, osition, toilet, groom, and feed imum Data Set (MDS) 4/19/16, identified R34 assistance with all ADL's. a.m. NA-E and NA-F were R34 with dressing as R34 had i-E and NA-F transferred R34 e of a mechanical lift. After NA-E and NA-F transferred	F	31:					
	R34 from the bed w	ith the use of a mechanical lift							

Facility ID: 00576

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CENTER	RS FOR MEDICARE	AND HUMAN SERVICES	1		OMB NC	1 APPRO\ 0. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		TE SURVEY MPLETED
		245548	B. WING		05	/19/2016
	PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP C 805 EAST 4TH STREET HILLS, MN 56138		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLE DATE
F 312	into her wheelchair. After putting a sweat they had completed NA- E and NA-F weat perform oral cares NA-F stated, "We hnow." The staff stat did not wear it becat then explained that teeth or swab her m When interviewed of stated oral cares sh R34 for the staff wh cares, further indica	nge 26 NA-E combed R34's hair. Atter on R34, staff indicated their morning cares for R34. After a long pause, haven't done it yet but we will ed R34 had a lower partial but nuse she did not like it in. NA-E staff should try to brush her nouth if R34 refused brushing. After a 8:32 a.m. RN-C nould have been completed for to assisted with morning ating R34 should have morning ares due to her poor dental	F 312		· ·	
	assessment dated required extensive a	ange in status MDS 4/19/16, indicated R26 assistance of two staff for e Area Assessment (CAA) for id not trigger.		· · ·		
1		assessment dated 4/18/16, oosely fitting upper dentures ral teeth.				
)	that R26 had Lewy assistance to place [dentures] at hour o cup. The care plan	t revised on 4/26/16, indicated Body dementia, required staff upper dentures and to soak f sleep (HS) in the denture also indicated R26's natural shed with AM and PM cares.				
	The nursing assista	nt assignment sheet dated				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION			
	FOORECHON	IDENTIFICATION NOWBER.	A. BUILDI	INC	G	COMPLETED		
		245548	B. WING			05/	19/2016	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 505 EAST 4TH STREET			
TUFF ME	MORIAL HOME				HILLS, MN 56138			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES	ID PREFI)	v	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION	
TAG		SC IDENTIFYING INFORMATION)	TAG	^ 	CROSS-REFERENCED TO THE APPROP DEFICIENCY)		DATE	
F 312	Continued From pa	ge 27	F 3	12	2			
	5/18/16, indicated F brushed.	R26 was to have his teeth						
	Morning cares were	e observed for R26 on 5/18/16,						
	at 7:44 a.m. At 8:1	7 a.m., NA-H indicated they ning cares for R26. No oral						
	cares were observe	ed to be provided. When				•		
		should have had oral cares idicated "Oh, shoot," and						
		have brushed R26's teeth and hould be in a cup in the						
	bathroom. Observa	tion at this time revealed R26						
	not been soaked as	s in his mouth and they had directed. NA-H indicated the						
	dentures had proba sometimes refused	bly been in all night as he oral care.						
		num Data Set (MDS)						
	required total assist	12/21/15, indicated he tance of two staff for					2	
		dental care area assessment 1 during the prior full MDS						
		d 5/18/16, indicated R1 had						
		I staff were to brush his lower nture. R1's nursing assistant						
		Iso dated 5/18/16, indicated						
	R1's Mouth/Throat/ Communication ass	Neck/Speech and sessment dated 7/20/15,						
	indicated R1 had te	eth in the lower gum line in wore upper dentures. The						
		entified R1 had terminal						
		5/16/16, at 6:44 p.m. family licated they had concerns that			-			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 245548 B. WING 05/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **505 EAST 4TH STREET** TUFF MEMORIAL HOME HILLS, MN 56138 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (X4) ID 1D (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 312 Continued From page 28 F 312 R1's routine oral cares were not being done consistently and that R1's dentures were not being placed in his mouth. During observation on 5/18/16, at 8:32 a.m. nursing assistant (NA)-G performed morning cares for R1. NA-G indicated R1 no longer wore dentures, stating "because he eats better without them." NA-H, also present during cares indicated R1 had not worn the dentures since 12/15. NA-G finished morning cares and assisted R1 into his wheelchair and proceeded to bring him to breakfast. When asked if NA-G intended to brush R1's teeth, she replied "We have never been directed to do that. I never have." NA-H was also present and indicated she did not usually brush R1's teeth or clean his mouth with cares. During interview on 5/18/16, at 10:01 a.m. the director of nursing (DON) indicated that all residents' teeth and mouth should be brushed and/or cleansed with morning and evening cares. The Tuff Memorial Home Oral Competency Checklist last reviewed 3/17/16, indicated staff were to brush dentures or teeth using personal brush and paste adhering to the resident's routine as much as possible. Soak dentures at HS in personal denture cup. 483.25(I) DRUG REGIMEN IS FREE FROM F 329 F 329 UNNECESSARY DRUGS SS=D 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

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

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245548	B. WING			05/	19/2016
NAME OF I	PROVIDER OR SUPPLIER	W W	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
TUFF ME	EMORIAL HOME				505 EAST 4TH STREET HILLS, MN 56138		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORREC PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APP DEFICIENCY)			(X5) COMPLETION DATE
F 329	indications for its us adverse consequer should be reduced combinations of the Based on a compre- resident, the facility who have not used given these drugs u therapy is necessar as diagnosed and o record; and residen drugs receive gradu behavioral intervent	e; or in the presence of nces which indicate the dose or discontinued; or any	F:	329		· ·	
	by: Based on interview facility failed to cons and non-pharmacol prior to the adminis anti-anxiety medica document effective and failed to complet to determine effective medication (Remen- reviewed for unneco Findings include: R48 was admitted to diagnoses including	NT is not met as evidenced and document review the sistently document behaviors ogical interventions attempted tration of a PRN (as needed) tion (Ativan), failed to ness of Ativan administration ete a sleep study assessment veness of an antidepressant on) for 1 of 5 residents (R48) essary medications.					

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		AND HUMAN SERVICES				FORM	: 06/17/2016 APPROVED . 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .		E CONSTRUCTION		E SURVEY IPLETED
		245548	B. WING	B		05/	/19/2016
NAME OF I	PROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE		
TUFF ME	EMORIAL HOME				05 EAST 4TH STREET IILLS, MN 56138		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 329	dated 4/3/16, revea for Mental Status (E severe cognitive im further indicated R4 assistance with all a exhibited rejection of behavior 1 to 3 days Review of the 4/12/ for R48 also reveale (milligram) po (by m anxiety; Give if agil looking for husband Start date of order-3 Review of R48's ca included: PRN Ative wanting to go home within 15 minutes. sewing blankets, tal giving [Ativan]. Review of the electri (eMAR) revealed R4 Ativan 35 times from review of R48's eM/ indicated document	sician orders. ay Minimum Data Set (MDS) led R48 had a Brief Interview BIMS) score of "3", indicating pairment. The assessment 8 required extensive activities of daily living and of care and wandering s during the look back period. 16, signed physician orders ed an order for Ativan 1 mg nouth) every 4 hours PRN for rated or wanting to go home, 1 3 times within 15 minutes;	F :	329	DEFICIENCY)		
	attempted prior to a and the effectivenes were only documen this time period. When interviewed of licensed practical ne	dministration of PRN Ativan ss following administration ted 15 out of 35 times during on 5/19/16, at 8:20 a.m. urse (LPN)-A stated R48's					
FORM CMS-25	PRN Ativan was on 67(02-99) Previous Versions		1	Fac	ility ID: 00576 If contin	nuation sheet	Page 31 of 43

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		AND HUMAN SERVICES				FORM	06/17/2016 APPROVED 0938-0391			
STATEMENT OF DEFICIENCI AND PLAN OF CORRECTION	ES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION 3	(X3) DAT	E SURVEY PLETED			
		245548	B. WING	۱ <u> </u>		05/19/2016				
NAME OF PROVIDER OR S	UPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE							
TUFF MEMORIAL HOME					505 EAST 4TH STREET HILLS, MN 56138					
PREFIX (EACH DE	FICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE			
effective. L. be impleme eMAR. LPN administere document ir description intervention When intervention RN-B review surveyor an consistently intervention RN-B also of consistently PRN Ativan reflect this. When intervention attempted p and in additi administered When intervention attempted p and in additi administered When intervention attervention attempted p and in additi administered When intervention and also sta Review of th Administrati	acologic PN-A co nted pri V-A furth d the m n the "co of R48's s attem viewed c urse (R cluded s r to adr ved R48 d confir docum s attem and wo viewed c harmac g R48's rior to a g R48's rior to a d ion, the d. viewed c harmac g R48's rior to a s attem and wo	al interventions are not onfirmed the interventions to or to use were listed on the her stated when PRN Ativan is edication nurse is required to omments" section a s behavior and the pted prior to administration. on 5/18/16, at 2:21 p.m. N)-B confirmed the eMAR and specific interventions to ninistering R48's PRN Ativan. B's PRN Ativan use with the med staff were not enting R48's behavior and pted prior to administration. d staff were also not enting the effectiveness of the uld expect documentation to on 5/19/16, at 9:25 a.m. the sist confirmed staff should be behavior and interventions administration of PRN Ativan effectiveness of each dose on 5/19/16, at 9:45 a.m. the DON) confirmed the dministering R48's PRN document behaviors and pted prior to administration, d document effectiveness.	F	329						

Event ID: QFKO11

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		AND HUMAN SERVICES					FORM	: 06/17/2016 APPROVED . 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DAT	E SURVEY IPLETED
		245548	B. WING				05/	19/2016
NAME OF	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE	Ξ		
TUFF M	EMORIAL HOME				EAST 4TH STREET LS, MN 56138			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD	BE	(X5) COMPLETION DATE
F 329	date, time, reason f the med and the sig Medication Aide] or with the charge nur- Further review of R- orders revealed an at HS (hour of sleep 3/3/16. The diagno was: Alzheimer's D Review of the physi 3/3/16 indicated Re initiated "to hopefull overnight." Review not include evidence been conducted afte so the efficacy of the assessed. When interviewed of confirmed R48's Re 3/3/16 for sleep dist a psychotropic med chart on the effectiv to give the medication resident's system. I staff will chart by ex disturbance. RN-B of assessment related Remeron was not co been. When interviewed of consulting pharmac initiation of Remeron response related to pharmacist further of	or giving, the effectiveness of gnature of TMA [Trained charge nurse. TMA's check se before giving a PRN med. 48's 4/12/16, signed physician order for Remeron 7.5 mg po b/bedtime) with a start date of sis indicated on the order visease. , cian progress note dated meron 7.5 mg at HS would be y induce some sedation of R48's medical record did e that a timely sleep study had er initiation of the medication e medication could be on 5/18/16, at 2:21 p.m. RN-B emeron had been ordered on urbance. RN-B stated when ication is initiated nursing will eness 14 days after initiation on time to get into the RN-B also stated the night ception related to sleep confirmed a sleep study to the effectiveness of R48's onducted and should have	F 32	29				

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		AND HUMAN SERVICES				NTED: 06/17/20 FORM APPROV B NO: 0938-03	ED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	F	X3) DATE SURVEY COMPLETED	<u>.</u>
		245548	B. WING			05/19/2016	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS; CITY, STATE, J	ZIP CODE		_
TUFF ME	EMORIAL HOME			505 EAST 4TH STREET HILLS, MN 56138			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD B THE APPROPRI		ж
F 329	Continued From pa week after the initia	tion of Remeron.	F 32	29			
	director of nursing (study to determine	on 5/19/16, at 9:45 a.m. the (DON) confirmed that a sleep efficacy had not been iation of R48's Remeron.					
							:
F 428 SS=D	483.60(c) DRUG R IRREGULAR, ACT	EGIMEN REVIEW, REPORT ON	F 42	28			
		of each resident must be nce a month by a licensed					
	the attending physic	ist report any irregularities to cian, and the director of reports must be acted upon.					
	by: Based on interview consulting pharmac consistent docume non-pharmacologic prior to administrati anti-anxiety medica the lack of docume effectiveness follow failed to identify the	NT is not met as evidenced y and document review the cist failed to identify the lack of ntation of behaviors and al interventions attempted on of a PRN (as needed) ition (Ativan), failed to identify ntation related to the ying Ativan administration and e need for a sleep study to as of an antidepressant					

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		AND HUMAN SERVICES				FORM): 06/17/2016 /I APPROVED). 0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION	(X3) DA	te survey Mpleted
		245548	B. WING			05	/19/2016
NAME OF	PROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
TUFF M	EMORIAL HOME				505 EAST 4TH STREET HILLS, MN 56138		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 428	medication (Remer reviewed for unnec Findings include:	on) for 1 of 5 residents (R48) essary medications.	F 4	128	3		
	diagnoses including dementia with beha 4/12/16 signed phys Review of the 14-da dated 4/3/16, revea for Mental Status (E severe cognitive im further indicated R4 assistance with all a exhibited rejection of behavior 1 to 3 days Review of the 4/12/ for R48 also revealed (milligram) po (by m anxiety; Give if agit looking for husband Start date of order-3 Review of R48's car	ay Minimum Data Set (MDS) led R48 had a Brief Interview MMS) score of "3", indicating pairment. The assessment 8 required extensive activities of daily living and of care and wandering s during the look back period. 16, signed physician orders ed an order for Ativan 1 mg outh) every 4 hours PRN for ated or wanting to go home, 3 times within 15 minutes;					
	wanting to go home within 15 minutes. sewing blankets, tal giving [Ativan]. Review of the electr (eMAR) revealed R4 Ativan 35 times from review of R48's eM4 indicated documenta	an every 4 hours if agitated or , looking for husband 3 times Fry PRN wine, talking about king about gardening before onic administration record 48 was administered PRN n 3/6/16 - 5/14/16. Further AR and electronic record ation related to R48's nd staff interventions					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245548	B. WING	€		05/ [,]	19/2016
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 505 EAST 4TH STREET		
TUFF MI	EMORIAL HOME				HILLS, MN 56138		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	attempted prior to a and the effectivene were only document this time period. When interviewed of licensed practical n PRN Ativan was on non-pharmacologic effective. LPN-A co be implemented pri eMAR. LPN-A furth administered the m document in the "co description of R48's interventions attem When interviewed of registered nurse (R care plan included attempt prior to adr RN-B reviewed R48 surveyor and confir consistently docum interventions attem RN-B also confirme consistently docum PRN Ativan and wo reflect this. When interviewed of consulting pharmac documenting R48's attempted prior to a and in addition, the administered.	administration of PRN Ativan ss following administration ited 15 out of 35 times during on 5/19/16, at 8:20 a.m. urse (LPN)-A stated R48's ly given if al interventions are not onfirmed the interventions to or to use were listed on the her stated when PRN Ativan is edication nurse is required to omments" section a s behavior and the pted prior to administration. on 5/18/16, at 2:21 p.m. N)-B confirmed the eMAR and specific interventions to ninistering R48's PRN Ativan. B's PRN Ativan use with the	F 4	428	3		

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		AND HUMAN SERVICES			FOR	D: 06/17/2016 MAPPROVED
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION	1	<u>O. 0938-0391</u> ATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	1	NG		MPLETED
		245548	B. WING		0	5/19/2016
NAME OF I	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COL		
TUFF ME	EMORIAL HOME			505 EAST 4TH STREET HILLS, MN 56138		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	D ID	PROVIDER'S PLAN OF CORRI	ECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY	WUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		HOULD BE	COMPLETION DATE
	Ativan would be to a interventions attemp and also staff shoul Review of the undat Administration inclu (13.) The PRN med date, time, reason for the med and the sig Medication Aide] or with the charge nurs Further review of R4 orders revealed and at HS (hour of sleep 3/3/16. The diagnos was: Alzheimer's D Review of the physic 3/3/16 indicated Rem initiated "to hopefully overnight." Review not include evidence been conducted after so the efficacy of the assessed. When interviewed of confirmed R48's Ref 3/3/16 for sleep dista a psychotropic medi chart on the effective to give the medicatio resident's system. F staff will chart by exc	dministering R48's PRN document behaviors and oted prior to administration, d document effectiveness. ted policy titled, Medication ded: d report shows med given, or giving, the effectiveness of nature of TMA [Trained charge nurse. TMA's check se before giving a PRN med. 48's 4/12/16, signed physician order for Remeron 7.5 mg po //bedtime) with a start date of sis indicated on the order isease. cian progress note dated meron 7.5 mg at HS would be y induce some sedation of R48's medical record did e that a timely sleep study had er initiation of the medication e medication could be n 5/18/16, at 2:21 p.m. RN-B meron had been ordered on urbance. RN-B stated when cation is initiated nursing will eness 14 days after initiation on time to get into the RN-B also stated the night ception related to sleep onfirmed a sleep study	F 42			
	assessment related	to the effectiveness of R48's onducted and should have				

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		AND HUMAN SERVICES				FORM	06/17/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245548	B. WING			05/	19/2016
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 505 EAST 4TH STREET		
TUFF ME	EMORIAL HOME				HILLS, MN 56138		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) Completion Date
F 428	been.	ge 37 on 5/19/16, at 9:45 a.m. the	F4	128			
	director of nursing (confirmed that a sle						
	consulting pharmac initiation of Remerc response related to pharmacist further assessment to dete	on 5/19/16, at 9:25 a.m. the cist stated within 5-7 days after on there should be some o sleep pattern. The confirmed a sleep study ermine effectiveness should ed within a week after the on.					
F 441 SS=D	regimen reviews da by the consulting pl related to: inadequ response to PRN A documentation rela prior to PRN Ativan monitoring for the e initiation.	ed on the monthly drug ated 3/15/16, 4/5/16 and 5/3/16 harmacist lacked any mention ate staff monitoring of R48's tivan, inconsistent ted to interventions attempted administration and the lack of effectiveness of Remeron after I CONTROL, PREVENT	F 4	141			
	Infection Control Pr safe, sanitary and c to help prevent the of disease and infe (a) Infection Contro	l Program stablish an Infection Control					

Facility ID: 00576

If continuation sheet Page 38 of 43

		AND HUMAN SERVICES				FORM): 06/17/2016 / APPROVED
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		IPLE CONSTRUCTION	(X3) DA). 0938-0391 TE SURVEY MPLETED
		245548	B. WING	i		05	/19/2016
NAME OF	PROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE		/10/2010
TUFF ME	EMORIAL HOME				505 EAST 4TH STREET HILLS, MN 56138		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO	BE	(X5) COMPLETION DATE
F 441	Continued From pa	ae 38	F4	14-	1		
	(1) Investigates, co	ntrols, and prevents infections			1		
	in the facility; (2) Decides what pr	ocedures, such as isolation,					
	should be applied to	o an individual resident; and ord of incidents and corrective					
	actions related to in						
	determines that a reprevent the spread isolate the resident. (2) The facility must communicable dises from direct contact will tra (3) The facility must hands after each dir hand washing is ind professional practice (c) Linens Personnel must han	ion Control Program esident needs isolation to of infection, the facility must prohibit employees with a ase or infected skin lesions with residents or their food, if ansmit the disease. require staff to wash their ect resident contact for which icated by accepted					
	by: Based on observati review the facility fai hygiene after cathete of 4 residents (R26) daily living. Findings include:	T is not met as evidenced on, interview and document led to ensure proper hand er cares was performed for 1 observed during activities of					

Facility ID: 00576

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		AND HUMAN SERVICES				FORM	06/17/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		e survey Pleted
		245548	B. WING			05/	19/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 05 EAST 4TH STREET		
TUFF ME	EMORIAL HOME				ILLS, MN 56138		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441	R26 required exten grooming and activ R26's care plan las that R26 had Lewy extensive assistance urinary catheter. On 5/18/16, at 7:44 and NA-H were obs cares for R26. NA- then proceeded to catheter into a grace dumped the conter 500 milliliters of urin container and put it NA-G, who was assist requested NA-H gri the bathroom. Still used to empty the up gloves from the full handed the clean g proceeded to apply before removing he completion of R26's as to whether she of washed her hands and before reachin additional clean glo clothing. NA-H ind should have done since During interview or director of nursing to be changing glow	nent dated 4/19/16, indicated sive assistance of two staff for ities of daily living (ADL). It revised on 4/26/16, indicated Body dementia, required ce with grooming and had a a.m. nursing assistant (NA)-G served performing morning -H applied clean gloves and drain urine from R26's urinary duate container. NA-H its containing approximately ne into the toilet, rinsed the t on the back of R26's toilet. sisting with R26's cares, ab another set of gloves from wearing the soiled gloves urine, NA-H grabbed a set of box mounted on the wall and ploves to NA-G. NA-H r R26's socks and shoes er soiled gloves. After s cares, NA-H was interviewed changed her gloves and after emptying R1's catheter g into the glove box to remove oves and applying R26's icated she could not recall, but	F	441		·	

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If continuation sheet Page 40 of 43

		AND HUMAN SERVICES				FOR	D: 06/17/2016
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mui A. Build		PLE CONSTRUCTION	(X3) DA	D. 0938-0391 ATE SURVEY MPLETED
		245548	B. WING	·		0/	5/1 9 /2016
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
TUFF MI	EMORIAL HOME				505 EAST 4TH STREET HILLS, MN 56138		
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	Continued From pa	ae 40	F4	[]	1		
F 465	The Hand Hygiene Home, dated 3/29/1 must be done any ti soiled, before and a of the bathroom, aft utensils or any used resident who has ar sanitizer e.g. C. Diff 483.70(h)	Policy of the Tuff Memorial 6 indicated hand washing me your hands are visibly fter eating, after personal use er handling dirty linen, soiled I dressings, and with any n infection not killed by hand	F 4				
SS=D	E ENVIRON The facility must pro	L/SANITARY/COMFORTABL wide a safe, functional, rtable environment for the public.					
	by: Based on observati review the facility fai were kept in working	T is not met as evidenced on, interview and document led to ensure wheelchairs repair for 2 of 2 residents d with torn wheelchair					
	Findings include:						
	required total assista total assistance for la	um Data Set (MDS) 2/21/15, indicated he ance of two staff for transfers, pcomotion in the wheelchair nable to be understood.					
	wheelchair was note left headrest, with ex the tear. Maintenand	n 5/18/16, at 1:42 p.m. R1's d with a 6" ripped area on the posed foam sticking out of ce (M)-A observed the area uld have been reported to					

If continuation sheet Page 41 of 43

		AND HUMAN SERVICES			FORM	06/17/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G		E SURVEY PLETED
		245548	B. WING		05/	19/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
TUFF ME	EMORIAL HOME			505 EAST 4TH STREET HILLS, MN 56138		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 465	maintenance by nu overnight shift who saw them on a dail procedure for repor- notebook at the nu- nothing was on his wheelchair. M-A fu believe there was a R28's quarterly Mir 3/22/16, included a Status (BIMS) scor impaired cognition. the resident require activities of daily liv On 5/16/16, at 4:17 sitting in her wheel armrests on the w/ with jagged edges armrest exposing t The right armrest a on the top of the ar- missing exposing t When interviewed maintenance supe maintenance supe maintenance issue write them down on nurses station. MS list several times th working. MS state with R28's w/c as h verbally by staff no- maintenance list. list located on a cli and confirmed R28 been added to the proceeded to R28'	rising, probably by the cleaned the wheelchairs and y basis. M-A indicated he rting was to write it down on a rsing station and verified notebook regarding R1's arther indicated he did not a formal policy regarding this. himum Data Set (MDS) dated be Brief Interview for Mental re of 3, indicating severely The MDS further indicated ed extensive assistance with all	F 46			

Facility ID: 00576

If continuation sheet Page 42 of 43

	ALTH AND HUMAN SERVICES CARE & MEDICAID SERVICES			FORM): 06/17/2016 APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DA). 0938-0391 TE SURVEY MPLETED
	245548	B. WING		05	/19/2016
NAME OF PROVIDER OR SUPI	PLIER	5	TREET ADDRESS, CITY, STATE, ZIP 05 EAST 4TH STREET IILLS, MN 56138		
PRÉFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
cause skin tea cleanable surfa the staff to let I does not audit concerns. MS responsible for	confirmed the jagged edges could ring as well as not being a ace. MS stated he depended upon him know about w/c issues as he the w/c's for maintenance further stated the night staff are cleaning of the w/c's and should and brought R28's torn w/c	F 465			

Facility ID: 00576

If continuation sheet Page 43 of 43

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A BUILDING 01	- MAIN BUILDING 01		TE SURVEY
		245548	B. WING		05	/17/2016
NAME OF F	PROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZI		
TUFF ME	MORIAL HOME			EAST 4TH STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENT!FYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HEAPPROPRIATE	(X5) COMPLETI DATE
K 000	INITIAL COMMEN	TS	K 000			
	FIRE SAFETY				0 11	\bot
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			OVED from J Linhoff at 2:33 pr	, Jun 17, 20	016	
	PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE UPON RECEIPT OF AN ACCEPTABLE POO ONSITE REVISIT OF YOUR FACILITY MAY CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN		ι 	2	
A Life Safety Code Sur Minnesota Department Fire Marshal Division. Tuff Memorial Home w substantial compliance participation in Medica Subpart 483.70(a), Life 2000 edition of Nationa Association (NFPA) 10	Survey was conducted by the ment of Public Safety, State ion. At the time of this survey, ne was found to be not in ance with the requirements for dicare/Medicaid at 42 CFR, , Life Safety from Fire, and the tional Fire Protection A) 101 Life Safety Code (LSC), ig Health Care Occupancies.		RECE	VED		
	PLEASE RETURN CORRECTION FO DEFICIENCIES (H	OR THE FIRE SAFETY		JUN 17		
	Health Care Fire II State Fire Marsha 445 Minnesota Str St. Paul, MN 5510	l Division eet, Suite 145		MN DEPT. OF PUB STATE FIRE MARSH	LIC SAFETY IAL DIVISION	
	By email to:					
BORATOR	Y DIREC OR'S OR PROV	DER/SUPPLIER REPRESENTATIVE'S SIG		TITLE	1	(X6) DATE
aly	Int		Acti	rd Administr	aler 1	13/1 dermined th

Facility ID: 00576

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

GENTER	NTERS FOR MEDICARE & MEDICAID SERVICES					UND NC	0.0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURV COMPLETE		
		245548		B. WING			05/17/2016	
AME OF P	ROVIDER OR SUPPLIER				ATE, ZIP CODE			
TUFF ME	EMORIAL HOME			ST 4TH STI MN 56138	REET			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS"	ATEMENT OF DEFICIENCI T BE PRECEDED BY FULL ENTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
K 000	THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO 1. A description of to correct the defic 2. The actual, or pr 3. The name and/or responsible for cor- prevent a reoccurrer Tuff Memorial Horr The original buildir one-story, has a pa- sprinkler protected construction; The 1st Addition w one-story, has no l protected and is of The 2nd Addition w one-story, has a fu- sprinkler protected construction; The 3rd Addition w one-story, has a fu- sprinkler protected construction; The 4th Addition w one-story, has no l protected and is of The 3rd Addition w one-story, has a fu- sprinkler protected construction; The 4th Addition w one-story, has no l protected and is of The facility has a fu- detection in the co- corridors which is department notific	n@state.mn.us ppenman@state.mn PRRECTION FOR EA ST INCLUDE ALL OF ORMATION: what has been, or wi	ACH THE II be, done date. date	K 000				

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

QFKO21

If continuation sheet Page 2 of 4

Printed: 05/24/2016 FORM APPROVED OMB NO. 0938-0391

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIEI IDENTIFICATION NUM			LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SU COMPLE	
		245548		B. WING		05/1	7/2016
					TATE, ZIP CODE REET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIE T BE PRECEDED BY FULL ENTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 000	assemblies, separa II(111) construction V(000) construction 50 beds and had a survey. Because the origin additions met the origin booklet was complet The requirement a NOT MET as evide NFPA 101 LIFE S/ Smoke barriers shi least a one half ho constructed in acco barriers shall be p atrium wall. Windo fire-rated glazing or steel frames. 8.3, 19.3.7.3, 19.3 This Standard is a Smoke barriers shi least a one half ho constructed in acco barriers shall be p atrium wall. Windo	ating the buildings of from the additions of n. The facility has a census of 45 at time al building and the foc construction types allo the facility was surve one (1) Form CMS-27 leted. A FETY CODE STANI all be constructed to bur fire resistance ratio ordance with 8.3. Sm ermitted to terminate by wired glass pan a.7.5 not met as evidenced bur fire resistance ratio cordance with 8.3. Sm ermitted to terminate by wired glass pan a.7.5 not met as evidenced bur fire resistance ratio cordance with 8.3. Sm ermitted to terminate by shall be protected bur fire resistance ratio contance with 8.3. Sm ermitted to terminate bur fire resistance ratio contance with 8.3. Sm ermitted to terminate bur fire resistance ratio contance with 8.3. Sm ermitted to terminate bur fire resistance ratio contance with 8.3. Sm ermitted to terminate bur fire resistance ratio contance with 8.3. Sm ermitted to terminate bur fire resistance ratio contance with 8.3. Sm ermitted to terminate bur fire resistance ratio contance with 8.3. Sm ermitted to terminate bur fire resistance ratio contance with 8.3. Sm ermitted to terminate bur fire resistance ratio contance with 8.3. Sm ermitted to terminate bur fire resistance ratio contance with 8.3. Sm ermitted to terminate bur fire resistance ratio c	f Type capacity of a of the our owed for yed as 786R 33.70(a) is DARD provide at noke at an d by els and hoke at an d by: provide at ing and noke at an d by: at an d by:	K 000			
	between the hour	pection on May 17, 2 s of 10:30 AM and 1: aled that the smoke b	00 PM,				

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

If continuation sheet Page 3 of 4

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

CENTER	TERS FOR MEDICARE & MEDICAID SERVICES		CES			OWB NC	0.0938-039	
TATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	R/CLIA		E CONSTRUCTION 01 - Main Building 01	(X3) DATE S COMPL		
		245548		B. WING		05/17/2016		
	ROVIDER OR SUPPLIER		505 EA	DRESS, CITY, STATE, ZIP CODE AST 4TH STREET , MN 56138				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIE T BE PRECEDED BY FULL I ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE	
K 025	Continued From p has a penetration lay-in ceiling.	age 3 around some cables a	above the	K 025				
	This was also observed Maintenance Direct	erved by the Facility otor.	E.					
K 147 SS=D	Electrical wiring ar accordance with N (NFPA 99) 18.9.1, This Standard is r Electrical wiring ar accordance with N (NFPA 99) 18.9.1, FINDINGS INCLU During the Facility between the hours 1:00 PM, an exter Resident Room # fixed wiring.	not met as evidenced nd equipment shall be lational Electrical Coo 19.9.1 IDE: Inspection on May 1	e in de. 9-1.2 by: e in de. 9-1.2 7, 2016, ved in purce of	K 147				
	Facility Maintenar		used to					

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

QFKO21

If continuation sheet Page 4 of 4

Alex Dysthe, Administrator

505 E. 4th Street Hills, MN 56138

Phone: 507-962-3275 Fax: 507-962-3277



TUFF MEMORIAL HOME, INC. Tuff Village Assisted Living & Tuff Retirement Apartments

TO: Larry Gannon, Supervisor Health Care Fire Inspections

RE: Tuff Memorial Home, Hills, MN: Plan of Correction

The following measures have been identified to correct these deficiencies:

K25

- 1. The hole around the cables was re-caulked using fire caulk.
- 2. The Tuff Memorial Home will be in compliance by May 23rd, 2016
- 3. The Maintenance Supervisor is responsible for monitoring compliance with this correction

K 147

- 1. The extension cord has been removed from Resident Room #4
- The Tuff Memorial Home will be in compliance by May 23rd, 2016
 The Administrator and Maintenance Supervisor are responsible for monitoring compliance with this correction.



Protecting, maintaining and improving the health of all Minnesotans

Certified Mail # 7013 3020 0001 8869 1029

June 1, 2016

Mr. Alex Dysthe, Administrator Tuff Memorial Home 505 East 4th Street Hills, MN 56138

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5548025

Dear Mr. Dysthe:

The above facility was surveyed on May 16, 2016 through May 19, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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.

Tuff Memorial Home June 1, 2016 Page 2

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:

Kathryn Serie, Unit Supervisor Health Regulation Division Minnesota Department of Health 1400 E. Lyon Street Marshall, Minnesota 56258 Email: <u>Kathryn.serie@state.mn.us</u> Office: (507) 476-4233 Fax: (507) 537-7194

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, Unit Supervisor, at (507) 476-4233.

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,

Kumala Fiske Downing

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

Enclosure(s)

cc: Original - Facility Licensing and Certification File

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STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	K3) DATE SURVEY COMPLETED
		00576	B. WING		05/19/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE	
	MORIAL HOME	HILLS, M	T 4TH STRE N 56138	ET	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLE
2 000	Initial Comments		2 000		
	*****ATTE	NTION*****			
	NH LICENSING	CORRECTION ORDER			
	144A.10, this correct pursuant to a surver found that the defice herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of t lack of compliance. re-inspection with a result in the assess	nether a violation has been			
	that may result from orders provided that the Department with	hearing on any assessments non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.			
	the State Licensing federal software. Ta assigned to Minneso Nursing Homes.	ent of Health is documenting Correction Orders using g numbers have been ota state statutes/rules for		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal soft Tag numbers have been assigned to Minnesota state statutes/rules for Nu Homes.	
	The assigned tag nu	umber appears in the far left			
DRATORY	DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGN	Λ.	TITLE	(X6) DATE
<u>IIII</u> Е FORM	- Sylt	Acting		nistrator FK011 RECEIVED "C	U/13/16

JUN 1 5 2016

Manestoa Department of Health Marshall

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY OMPLETED
		00576	B. WING	0	5/19/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE	
TUFF ME	MORIAL HOME		T 4TH STREE IN 56138	T	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
2 000	Initial Comments		2 000		
	****ATTE	NTION*****			
	NH LICENSING	CORRECTION ORDER			
	144A.10, this corre pursuant to a surve found that the defic herein are not corre not corrected shall	Minnesota Statute, section ction order has been issued ey. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance fines promulgated by rule of artment of Health.			
	corrected requires requirements of the number and MN Re When a rule contai comply with any of lack of compliance re-inspection with a result in the assess	hether a violation has been compliance with all a rule provided at the tag ule number indicated below. Ins several items, failure to the items will be considered . Lack of compliance upon any item of multi-part rule will sment of a fine even if the item uring the initial inspection was			
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.			
	the State Licensing federal software. Ta	TS: nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal softwar Tag numbers have been assigned to Minnesota state statutes/rules for Nursir Homes.	
	The assigned tag n	umber appears in the far left			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		00576	B. WING		05/1	9/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
	MORIAL HOME		T 4TH STRE IN 56138	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 000	statute/rule out of c "Summary Stateme and replaces the "T correction order. Th findings which are i after the statement, evidence by." Follow are the Suggested Time period for Cor PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA THERE IS NO REC PLAN OF CORREC	Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the his column also includes the n violation of the state statute "This Rule is not met as wing the surveyors findings Method of Correction and rection. RD THE HEADING OF THE	2 000	The assigned tag number app far left column entitled "ID Pr The state statute/rule number corresponding text of the state out of compliance is listed in t "Summary Statement of Defic column and replaces the "To portion of the correction order column also includes the find are in violation of the state sta statement, "This Rule is not n evidenced by." Following the findings are the Suggested M Correction and the Time Peric Correction. PLEASE DISREGARD THE F THE FOURTH COLUMN WH STATES, "PROVIDER'S PLA CORRECTION." THIS APPLI FEDERAL DEFICIENCIES O WILL APPEAR ON EACH PA THERE IS NO REQUIREMEN SUBMIT A PLAN OF CORRE VIOLATIONS OF MINNESO STATUTES/RULES.	efix Tag." and the e statute/rule the ciencies" Comply" This dings which atute after the net as e surveyors ethod of od For HEADING OF ICH N OF ES TO NLY. THIS GE. NT TO CTION FOR	
2 302	MN State Statute 1 or related disorder	44.6503 Alzheimer's disease train	2 302			
	ALZHEIMER'S DIS DISORDER TRAIN MN St. Statute 144					
	Alzheimer's disease or related of	ity serves persons with disorders, whether in a eral unit, the facility's direct				

QFKO11

If continuation sheet 2 of 47

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED		
		00576	B. WING		05/	19/2016		
NAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE					
TUFF ME	EMORIAL HOME	505 EAST HILLS, M	4TH STREE N 56138	г				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE		
2 302	Continued From pa	ige 2	2 302					
	care staff and their superviso care.	rs must be trained in dementia						
	related disorders; (2) assistance with (3) problem solving and (4) communication (c) The facility shall written or electronic training program, the trained, the frequent topics covered.	of Alzheimer's disease and activities of daily living; with challenging behaviors;						
	by: Based on interview facility failed to prov electronic format a training program, c	ent is not met as evidenced and document review, the vide to consumers in written or description of the Alzheimer's ategories of employees of training and basic topics						
	Findings include:							
	work designee (SS documentation ava provided any inform training in electronic public. The SSD sta	5/17/16, at 3:1 p.m. the social D) indicated there was no ilable indicating the facility nation related to Alzheimer's c or written materials for the ated, " I guess I was not I to ensure provided in written t]. "						

Minnesota Department of Health STATE FORM

6899

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If continuation sheet 3 of 47

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00576	B. WING		05/	19/2016	
NAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
	EMORIAL HOME		T 4TH STREET IN 56138	r			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 302	Continued From pa	ige 3	2 302				
	facility could revise materials to include regarding their train staff trained, and co to ensure consume	THOD OF CORRECTION: The their written and electronic e necessary information ning program and categories o reate policies and procedures ers are informed of this A committee could audit for					
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one					
2 565	MN Rule 4658.040 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565				
		omprehensive plan of care I personnel involved in the t.					
	by: Based on observat review the facility fa provided in accorda 4 residents (R26, F activities of daily liv failed to follow the o documentation of in as needed (PRN) A	nterventions attempted prior to Ativan (anti-anxiety medication) ents (R48) reviewed for					
	Findings include:						
	R26's significant ch	ange in status MDS					

QFKO11

STATEMEN	Dita Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00576	B. WING		05/	19/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
TUFF ME	EMORIAL HOME		T 4TH STREET IN 56138	г		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 4	2 565			
	required extensive	4/19/16, indicated R26 assistance of two staff for re Area Assessment (CAA) for lid not trigger.				
	that R26 had Lewy assistance to place [dentures] at hour of cup. The care plan	at revised on 4/26/16, indicated Body dementia, required staff e upper dentures and to soak of sleep (HS) in the denture n also indicated R26's natural ushed with AM and PM cares.				
	The nursing assista 5/18/16, indicated brushed.	ant assignment sheet dated R26 was to have his teeth				
	at 7:44 a.m. At 8:1 had completed mo cares were observe asked whether R26 completed, NA-H in stated she should I that his dentures sh bathroom. Observe still had his denture not been soaked a	e observed for R26 on 5/18/16 17 a.m., NA-H indicated they rning cares for R26. No oral ed to be provided. When 6 should have had oral cares ndicated "Oh, shoot," and have brushed R26's teeth and hould be in a cup in the ation at this time revealed R26 es in his mouth and they had s directed. NA-H indicated the ably been in all night as he d oral care.				
	director of nursing residents' teeth and	n 5/18/16, at 10:01 a.m. the (DON) indicated that all d mouth should be brushed ith morning and evening cares the care plan.				
	Checklist, last revie were to brush dent	Home Oral Competency ewed 3/17/16 indicated staff ures or teeth using personal dhering to the resident's routine				

QFKO11

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00576	B. WING	3. WING		05/19/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•		
TUFF ME	EMORIAL HOME		T 4TH STREET IN 56138	г			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 565	Continued From pa	age 5	2 565				
	as much as possib personal denture c	le. Soak dentures at HS in up.					
	in the plan of care. to the physician or	le dental care for R28 as stated R28 had diagnoses according ders dated 4/7/16, which a, major depression, psychosis mer's disease.					
	R28 would be able	blan dated 3/29/16, identified to participate in oral cares on care plan identified staff would I care supplies.					
	assessment dated	nimum Data Set (MDS) 3/22/16, identified R28 assistance of one staff with all ring (ADL's).					
	at 8:06 a.m. nursin R28 out of bed. N/ bedside commode washing, dressing toileting. At 8:18 a the commode into and walker. NA-B o R28 whether she w NA-B was preparin if oral cares were g	of morning cares on 5/19/16, g assistant (NA)-B assisted A-B transferred R28 onto a and assisted R28 with face and perineal cares after .m. NA-B transferred R28 from her wheelchair using a gait bel combed R28's hair and asked vas ready to go to breakfast. Ing to exit the room when asked going to be completed. NA-B s I can do them after	t				
	breakfast. Do you t NA-B stated she w breakfast. NA-B fu	s I can do them after think I should do them now." ould do the oral cares after rther stated staff were o R28's oral supplies and orush her teeth.					
	registered nurse (F	on 5/19/16, at 8:32 a.m. RN)-C stated oral cares should ng morning and bedtime cares.					

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED 05/19/2016	
	00576	B. WING			
PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
EMORIAL HOME			r		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
Continued From pa	age 6	2 565			
oral cares when ge morning to ensure	tting the residents up in the if they have dentures placed				
to the plan of care. assessment dated which included: de	According to the quarterly 4/19/16, R34 had diagnoses pression, anemia, anxiety,				
R34 at risk for nutri teeth and significar further identified R2 wheel, transfer, rep	itional deficit related to loose at weight loss. The care plan 28 was unable to bathe, dress, position, toilet, groom, and feed				
assessment dated	4/19/16, identified R34				
observed to assist a morning bath. NA into bed with the us they dressed R34, R34 from the bed v into her wheelchair After putting a sweat they had completed NA- E and NA-F we perform oral cares NA-F stated, "We h now." The staff stat did not wear it becat then explained that	R34 with dressing as R34 had A-E and NA-F transferred R34 se of a mechanical lift. After NA-E and NA-F transferred with the use of a mechanical lift. NA-E combed R34's hair. ater on R34, staff indicated d their morning cares for R34. ere asked if they were going to for R34. After a long pause, naven't done it yet but we will ted R34 had a lower partial but ause she did not like it in. NA-E staff should try to brush her	t .			
	OF CORRECTION PROVIDER OR SUPPLIER EMORIAL HOME SUMMARY ST/ (EACH DEFICIENC) REGULATORY OR L Continued From par RN-C stated she w oral cares when ge morning to ensure and their mouths cl Dental care was not to the plan of care. assessment dated which included: de congestive heart far R34's active care p R34 at risk for nutri- teeth and significar further identified R2 wheel, transfer, rep self independently. R34's quarterly Mir assessment dated required extensive On 5/19/16 at 6:36 observed to assist a morning bath. NA into bed with the us they dressed R34, R34 from the bed v into her wheelchair After putting a swe- they had completed NA-E and NA-F way perform oral cares NA-F stated, "We finow." The staff stat did not wear it becat then explained that teeth or swab her r	OF CORRECTION IDENTIFICATION NUMBER: 00576 PROVIDER OR SUPPLIER STREET AI SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 RN-C stated she would expect staff to provide oral cares when getting the residents up in the morning to ensure if they have dentures placed and their mouths clean for breakfast. Dental care was not provided for R34 according to the plan of care. According to the quarterly assessment dated 4/19/16, R34 had diagnoses which included: depression, anemia, anxiety, congestive heart failure and hypertension. R34's active care plan dated 4/26/16, identified R34 at risk for nutritional deficit related to loose teeth and significant weight loss. The care plan further identified R28 was unable to bathe, dress, wheel, transfer, reposition, toilet, groom, and feec self independently. R34's quarterly Minimum Data Set (MDS) assessment dated 4/19/16, identified R34 required extensive assistance with all ADL's. On 5/19/16 at 6:36 a.m. NA-E and NA-F were observed to assist R34 with dressing as R34 had a morning bath. NA-E and NA-F transferred R34 from the bed with the use of a mechanical lift into her wheelchair. NA-E combed R34's hair. After putting a sweater on R34, staff indicated they had completed their morning cares for R34. NA-E and NA-F were asked if they were going to perform oral cares for R34. After a long pause, NA-F stated, "We haven't done it yet but we will now." The staff stated R34 had a lower partial but did not wear it because she did not like it in. NA-E then explained that staff should try to brush her teeth or swab her mouth if R34 ref	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00576 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST SMORIAL HOME 505 EAST 4TH STREET HILLS, MN 56138 ID PROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Continued From page 6 2 565 RN-C stated she would expect staff to provide oral cares when getting the residents up in the morning to ensure if they have dentures placed and their mouths clean for breakfast. Penetral care was not provided for R34 according to the plan of care. According to the quarterly assessment dated 4/19/16, R34 had diagnoses which included: depression, anemia, anxiety, congestive heart failure and hypertension. R34's active care plan dated 4/26/16, identified R34 at risk for nutritional deficit related to loose teeth and significant weight loss. The care plan further identified R28 was unable to bathe, dress, wheel, transfer, reposition, toilet, groom, and feed self independently. R34's quarterly Minimum Data Set (MDS) assessment dated 4/19/16, identified R34 required extensive assistance with all ADL's. On 5/19/16 at 6:36 a.m. NA-E and NA-F were observed to assist R34 with dressing as R34 had a morning bath. NA-E and NA-F transferred R34 into bed with the use of a mechanical lift. After they dressed R34, NA-E and NA-F transferred R34 into bed with the use of a mechani	OF CORRECTION DENTIFICATION NUMBER: A. BUILDING: 00576 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SMORIAL HOME S05 EAST 4TH STREET HILLS, MN 561338 HILLS, MN 561338 WEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PREFIX CAROSE-REFERENCES Continued From page 6 2 565 2 565 RN-C stated she would expect staff to provide oral cares when getting the residents up in the morning to ensure if they have dentures placed and their mouths clean for breakfast. PREFIX PREFIX PREFIX CROSE-REFERENCES Dental care was not provided for R34 according to the plan of care. According to the quarterly assessment dated 419/16, R34 had diagnoses which included: depression, anemia, anxiety, congestive heart failure and hypertension. R34's active care plan dated 4/26/16, identified R34 at risk for nutritional deficit related to loose teeth and significant weight loss. The care plan further identified R28 was unable to bathe, dress, wheel, transfer, reposition, toilet, groom, and feed self independently. R34's quarterly Minimum Data Set (MDS) assessment dated 4/19/16, identified R34 required extensive assistance with all ADL's. On 5/19/16 at 6:36 a.m. NA-E and NA-F transferred R34 from the bus of a mechanical lift, into be with the use of a mechanical lift, into be dwith the use of a mechanical lift, into be dwith the use of a mechanical lift, into bed with the use of a mechanical lift, into be dwith the use of a m	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: COM 00576 B. WING 05/ PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL ID REQUARTORY ON LSC DEMIFYING INFORMATION) ID PREFX PROVIDERS PLAN OF CORRECTION AUDU DE (EACH OPERCETIVE AUTON SHOULD BE ICADS REFERENCE TO THE APPROPRIATE DEFICIENCY MUST BE PRECEDED BY FULL ID PREFX CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY Continued From page 6 RN-C stated she would expect staff to provide oral cares when getting the residents up in the morning to ensure if they have dentures placed and their mouths Celan for breakfast. 2 565 Dental care was not provided for R34 according to the plan of care. According to the quarterly assessment dated 4/19/16, R34 had diagnoses which included: depression, anemia, anxiety, congestive heart failure and hypertension. R34's active care plan dated 4/26/16, identified R34 at risk for nutritional deficit related to loose teeth and significant weight loss. 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STATEMEN	It of Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00576	B. WING		05/19/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
TUFF ME	EMORIAL HOME	505 EAST HILLS, MI	4TH STREE	r		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 7	2 565			
	R34 for the staff wh cares, further indicated	hould have been completed for no assisted with morning ating R34 should have morning ares due to her poor dental				
	with diagnoses incl	Imitted to the facility 1/21/16 uding: Alzheimer's disease behavioral disturbance per the sician orders.				
	assessment dated Interview for Menta indicating severe co assessment further extensive assistant living and exhibited	ay Minimum Data Set (MDS) 4/3/16, revealed a Brief Il Status (BIMS) score of "3" ognitive impairment. The r identified R48 required ce with all activities of daily I rejection of care and r 1 to 3 days during the look				
	revealed an order f every 4 hours PRN wanting to go home	/16, signed physician orders for Ativan 1 mg po (by mouth) for anxiety. Give if agitated or e, looking for husband 3 times Start date of order 3/3/16.				
	included: PRN Ativ wanting to go home within 15 minutes.	plan last revised 5/2/16, van every 4 hours if agitated or e, looking for husband 3 times Try PRN wine, talking about nd talking about gardening				
	(eMAR) revealed F Ativan 35 times fro review of the reside record indicated do	ronic administration record 48 was administered PRN m 3/6/16 - 5/14/16. Further ent's eMAR and electronic ocumentation related to R48's and staff interventions				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00576	B. WING		05/19/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
TUFF ME	EMORIAL HOME	505 EAS ⁻ HILLS, M	T 4TH STREET	r		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 565	Continued From pa	age 8	2 565			
		administration of Ativan, and ving administration were only t of 35 times.				
	licensed practical r PRN Ativan is only interventions are no the interventions pr eMAR. LPN-A furti given the medicatio "comments" sectio	on 5/19/16, at 8:20 a.m. nurse (LPN)-A stated R48's given if non-pharmacological ot effective. LPN-A confirmed rior to use were listed on the her stated when PRN Ativan is on nurse is to document in the n a description of R48's rentions attempted prior to				
	registered nurse (F care plan included attempt prior to adu RN-B reviewed R4 surveyor and confin consistently docum interventions attem RN-B further confir consistently docum	on 5/18/16, at 2:21 p.m. RN)-B confirmed the eMAR and specific interventions to ministering R48's PRN Ativan. 8's PRN Ativan use with the med staff were not tenting R48's behavior and pted prior to administration. med staff were also not tenting the effectiveness of the build expect charting to reflect				
	director of nursing expectation when g be to document be attempted prior to a	on 5/19/16, at 9:45 a.m. the (DON) confirmed the giving R48's PRN Ativan would haviors and interventions administration, and to also mess as identified on the plan				
	The director of nurs re-educate staff on	THOD OF CORRECTION: sing (DON) or designee could following resident care plans. nee could develop and				

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION		E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
		00576	B. WING		05/	19/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
TUFF ME	EMORIAL HOME	505 EAST HILLS, M	「4TH STREE ⁻ N 56138	Т		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	ge 9	2 565			
	implement an audit quality assurance p compliance.	ing system as part of their rogram to maintain				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 570	MN Rule 4658.0409 Plan of Care; Revis	5 Subp. 4 Comprehensive ion	2 570			
	care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent p participation of the guardian or chosen quarterly and within	resident, the resident's legal representative at least seven days of the revision of resident assessment required				
	by: Based on observati review the facility fa was updated with re	ent is not met as evidenced on, interview and document illed to ensure the plan of care egard to the use of dentures of 3 residents (R1) reviewed v living.				
	Findings include:					
	assessment dated required total assist grooming. An oral/	num Data Set (MDS) 12/21/15, indicated he tance of two staff for dental care area assessment 1 during the prior full MDS				

STATEMEN	It OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00576	B. WING		05/19/2016	
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE, ZIP CODE		10/2010
TUFF ME	EMORIAL HOME	505 EAS ⁻ HILLS, M	□ 4TH STREE N 56138	г		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE
2 570	Continued From pa	age 10	2 570			
	assessment.					
	upper dentures and teeth and upper de	ed 5/18/16, indicated R1 had d staff were to brush his lower nture. R1's nursing assistant also dated 5/18/16, indicated be brushed.				
	indicated R1 had te poor condition and	sessment dated 7/20/15, beth in the lower gum line in wore upper dentures. The indentified R1 had terminal				
	nursing assistant (I cares for R1. NA-C dentures stating, " them." NA-H, also cares indicated R1	on 5/18/16, at 8:32 a.m. NA) -G performed personal G indicated R1 no longer wore because he eats better without present in the room during had not worn the dentures D15 (5 months prior).				
	practical nurse (LP usually wear his de weight and the den	n 5/17/16, at 1:25 p.m. licensed N)-A confirmed R1 did not entures as he had lost so much tures were very loose. LPN-A was not a concern for R1 as he served at meals.				
	director of nursing	n 5/18/16, at 10:01 a.m. the (DON) indicated that R1's care een updated to include the fact ger wore dentures.				
	upedated 4/22/16 in	Home Care Plan policy, last ndicated each care plan would 90 days as required by law.				
	SUGGESTED MET	THOD OF CORRECTION: The				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00576	B. WING		05/19/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
TUFF ME	EMORIAL HOME	505 EAST HILLS, M	「4TH STREET N 56138	Г		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 570	director of nursing of provide training for current policy relate plan revisions. The assurance committ audits to ensure co	(DON) or designee, could all nursing staff and review ed to the timeliness of care e quality assessment and ee could perform random mpliance.	2 570			
2 830	(21) days. MN Rule 4658.0520 Proper Nursing Car Subpart 1. Care in	general. A resident must	2 830			
	custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.				
	by: Based on observati review, the facility f	ent is not met as evidenced ion, interview and document ailed to ensure services were e hospice agency for 1 of 1 ewed for hospice.				
		num Data Set (MDS) 12/21/15, indicated he				

STATEMEN	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00576	B. WING		05/19/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
TUFF ME	EMORIAL HOME		T 4TH STREET IN 56138	r		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From par required total staff daily living and was R1's care plan date received hospice sitogether with hospic resident's needs, co care plan further id health aide visits w R1's hospice plan of he received skilled weekly and as need two times per mont weekly and chaplai During observation was observed lying boots on, and show distress. R1 was u verbally. During observation nursing assistant (f performing cares w communicate and n staff to get out of b complete morning of discomfort were ob During interview or indicated he though coming to spend tin communicated durin nurse during report	age 12 assistance in all activities of a not able to be understood. ed 5/18/16, identified that R1 ervices and staff were to work ce staff to communicate oncerns and comments. The entified R1 received home eekly. of care dated 5/6/16, indicated nursing visits one to two times ded, social worker visits one to th, home health aide visits in visits once per month. on 5/17/16, at 12:34 p.m. R1 in his bed with heel protector wed no nonverbal signs of mable to communicate on 5/18/16, at 8:32 a.m. NA)-G was observed <i>v</i> ith R1. R1 was unable to required total assistance from ed into his wheelchair and cares. No signs of pain or oserved with transfers. n 5/17/16, at 1:23 p.m. NA-I nt there was an hospice aide me with R1 today as it was ing report from the charge t. NA-I was not sure whether	2 830			
	for R1. During interview on	e schedule of visits established n 5/17/16, at 1:31 p.m. licensed N)-A indicated hospice used to	1			

	NT OF DEFICIENCIES I OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00576	B. WING		05/	19/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
TUFF MI	EMORIAL HOME	505 EAST HILLS, MI	4TH STREET N 56138	r		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	provide a calendar visits and used hav baths for R1 and po beneficial for him; H only assist with fee LPN-A indicated the lot of changes rece they come, they co with our business." During interview on registered nurse (F agency used to pro- however, confirmed provides this inform During interview on medication aide (Th unsure what hospic indicated she work TMA-A indicated sh communication reg unless it involved m During interview on hospice RN-F indic social services and findings. RN-F ver with feeding and th facility staff. RN-F hospice staff to doo schedule book loca station. When interviewed of director of nursing provide a calendar however, no longer	identifying their scheduled ve hospice staff provide bed erform skin care which were however, but now hospice staff ding R1 due to weight loss. e hospice agency had made a ently and indicated "I guess if me and if they don't, we go on a 5/17/16, at 1:33 a.m. RN)-E indicated the hospice hyde their schedule of visits; d the agency no longer hation. a 5/18/16, at 7:41 a.m. trained MA)-A indicated she was be was providing for R1 and ed full-time at the facility. he did not receive any parding the hospice services,	2 830			

STATE FORM

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00576	B. WING		05/19/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
TUFF ME	EMORIAL HOME	505 EAST HILLS, M	□ 4TH STREE N 56138	г		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ige 14	2 830			
	staff after they cam	e to provide services.				
	indicated the hospid the visit to report ar documentation on h sure why they no lo stating that was hel staff to coordinate of hospice visits vary a schedule book that During interview on indicated that hospi	5/18/16, at 9:55 a.m. the SSD ce nurse visited with her after ny problems and left her ner desk. The SSD was not onger provided a calendar, lpful communication for facility cares. The SSD indicated the and she was unaware of any hospice visits are recorded. 5/18/16, at 10:06 a.m. RN-B ice had quit providing				
	anymore. RN-B fur staff did not come p	not write down there visits ther stated that since hospice prior to R1 getting up for the vere not beneficial for him.				
	hospice RN-F indic hospice providing a cares for R1, "I will	on 5/18/2016, at 11:39 a.m. ated with regard to the lack of a schedule and coordinating just take it, it is my fault there will go back to the calendars."				
	last updated 3/29/1 Home staff remain hospice staff are us	of the Tuff Memorial Home 6, indicated The Tuff Memorial the primary caregivers and the sed in addition to this to and family with physical and e issues.				
	The director of nurs meet with all contra facility staff to revie hospice services ar DON or designee c ensure compliance	THOD OF CORRECTION: sing (DON) or designee, could acted hospice providers and w current policy related to nd coordination of care. The sould perform random audits to and review findings at quality ssurance committee meetings.				

	IT OF DEFICIENCIES OF CORRECTION	Alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00576	B. WING		05/	19/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
TUFF ME	MORIAL HOME	505 EAST HILLS, M	F 4TH STREET N 56138	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ge 15	2 830			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 920	MN Rule 4658.052	5 Subp. 6 B Rehab - ADLs	2 920			
	comprehensive res home must ensure B. a resident who activities of daily liv	is unable to carry out ing receives the necessary n good nutrition, grooming,				
	by: Based on observati review the facility fa completed for 4 of 4	ent is not met as evidenced ion, interview and document ailed to ensure oral cares were 4 residents (R28, R34, R26, ctivities of daily living (ADL).				
	Findings include:					
	required extensive had diagnoses accordated 4/7/16, which	e dental care for R28, who assistance with all ADL's. R28 ording to the physician orders n included: dementia, major sis, anxiety and Alzheimer's				
	R28 would be able	lan dated 3/29/16, identified to participate in oral cares on are plan identified staff would care supplies.				
	assessment dated	imum Data Set (MDS) 3/22/16, identified R28 assistance of one staff with all				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00576	B. WING		05/19/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
TUFF ME	EMORIAL HOME		T 4TH STREET IN 56138	г		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 920	Continued From pa	age 16	2 920			
	activities of daily liv	ring (ADL's).				
	During observation of morning cares on 5/19/16, at 8:06 a.m. nursing assistant (NA)-B assisted R28 out of bed. NA-B transferred R28 onto a bedside commode and assisted R28 with face washing, dressing and perineal cares after toileting. At 8:18 a.m. NA-B transferred R28 from the commode into her wheelchair using a gait belt and walker. NA-B combed R28's hair and asked R28 whether she was ready to go to breakfast. NA-B was preparing to exit the room when asked if oral cares were going to be completed. NA-B stated, "Oh, I guess I can do them after breakfast. Do you think I should do them now." NA-B stated she would do the oral cares after breakfast. NA-B further stated staff were supposed to set up R28's oral supplies and encourage her to brush her teeth.		t			
	registered nurse (F be completed durin RN-C stated she w oral cares when ge	on 5/19/16, at 8:32 a.m. RN)-C stated oral cares should ing morning and bedtime cares. yould expect staff to provide etting the residents up in the if they have dentures placed lean for breakfast.				
	required extensive According to the qu 4/19/16, R34 had c	ot provided for R34, who assistance with ADL's. uarterly assessment dated diagnoses which included: a, anxiety, congestive heart nsion.				
	R34 at risk for nutr teeth and significar further identified R	plan dated 4/26/16, identified itional deficit related to loose nt weight loss. The care plan 28 was unable to bathe, dress, position, toilet, groom, and feed				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00576	B. WING		05/	05/19/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE	•		
TUFF ME	MORIAL HOME	505 EAS HILLS, M	T 4TH STREET	Г			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ^Y	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 920	Continued From pa	age 17	2 920				
	self independently.						
	assessment dated	nimum Data Set (MDS) 4/19/16, identified R34 assistance with all ADL's.					
	observed to assist a morning bath. NA into bed with the us dressed R34 and p NA-E and NA-F the bed with the use of wheelchair. NA-E of putting a sweater of completed their more and NA-F were ask perform oral cares NA-F stated, "We h now." The staff stat did not wear it beca then explained that teeth or swab her m When interviewed of stated oral cares sl R34 for the staff wh cares, further indica	a.m. NA-E and NA-F were R34 with dressing as R34 had A-E and NA-F transferred R34 se of a mechanical lift. They blaced an incontinent brief. en transferred R34 from the a mechanical lift into her combed R34's hair. After on R34, staff indicated they had brining cares for R34. NA- E ked if they were going to for R34. After a long pause, naven't done it yet but we will ted R34 had a lower partial but ause she did not like it in. NA-E t staff should try to brush her nouth if R34 refused brushing. on 5/19/16, at 8:32 a.m. RN-C hould have been completed for no assisted with morning ating R34 should have morning are due to the poor dental					
	status. R26's significant ch assessment dated required extensive	nange in status MDS 4/19/16, indicated R26 assistance of two staff for re Area Assessment (CAA) for					
		assessment dated 4/18/16, loosely fitting upper dentures ural teeth.					

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00576	B. WING		05/19/2016		
NAME OF F	ROVIDER OR SUPPLIER		T ADDRESS, CITY, STATE, ZIP CODE				
IUFF ME	MORIAL HOME	505 EAS ⁻ HILLS, M	T 4TH STREET N 56138	r			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 920	Continued From pa	age 18	2 920				
	that R26 had Lewy assistance to place [dentures] at hour of cup. The care plar teeth should be bru The nursing assists 5/18/16, indicated brushed. Morning cares wer at 7:44 a.m. At 8:1 had completed mo cares were observe asked whether R26 completed, NA-H in stated she should I that his dentures s bathroom. Observe still had his denture not been soaked a dentures had proba sometimes refused R1's quarterly Mini	mum Data Set (MDS)					
	required total assis grooming. An oral	12/21/15, indicated he stance of two staff for /dental care area assessment R1 during the prior full MDS					
	upper dentures and teeth and upper de	ed 5/18/16, indicated R1 had d staff were to brush his lower enture. R1's nursing assistant also dated 5/18/16, indicated be brushed.					
nacata Da	R1's Mouth/Throat	/Neck/Speech and					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00576	B. WING		05/19/20	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE	•	
TUFF ME	MORIAL HOME	505 EAST HILLS, MI	4TH STREET N 56138	Г		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From pa	age 19	2 920			
	indicated R1 had te poor condition and assessment also ic multiple sclerosis (During interview or member (FM)-A ind R1's routine oral ca consistently and th being placed in his During observation nursing assistant (I cares for R1. NA-G dentures, stating "b them." NA-H, also indicated R1 had n 12/15. NA-G finish assisted R1 into his bring him to breakf intended to brush F have never been d have." NA-H was a	n 5/16/16, at 6:44 p.m. family dicated they had concerns that ares were not being done at R1's dentures were not				
	director of nursing residents' teeth and	n 5/18/16, at 10:01 a.m. the (DON) indicated that all d mouth should be brushed th morning and evening cares.				
	Checklist last revie were to brush dent brush and paste ad	Home Oral Competency wed 3/17/16, indicated staff ures or teeth using personal thering to the resident's routine le. Soak dentures at HS in up.				
	SUGGESTED ME	THOD OF CORRECTION:				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00576	B. WING		05/	05/19/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
TUFF MI	EMORIAL HOME	505 EAS ⁻ HILLS, M	F 4TH STREET N 56138				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 920	Continued From pa	ige 20	2 920				
	provide education of providing morning of residents per the pl conducted to ensur staff. The results of assurance committed	sing (DON) or designee, could on the performance of oral care consistently to lan of care. An audit could be re oral care is provided by ould be reported to the quality ee. R CORRECTION: Twenty-one					
21390	MN Rule 4658.080	0 Subp. 4 A-I Infection Control	21390				
	control program mu procedures which p A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service en prevention and con E. a resident h immunization progr defined in part 465 procedures of resid the prevention and F. the develop employee health po practices, including defined in part 465 G. a system fo H. a system for	ealth program including an am, a tuberculosis program as 8.0810, and policies and lent care practices to assist in treatment of infections; ment and implementation of plicies and infection control a tuberculosis program as 8.0815; r reviewing antibiotic use; r review and evaluation of ect infection control, such as eptics, gloves, and					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00576	B. WING		05/	19/2016
AME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
UFF ME	EMORIAL HOME	505 EAS ⁻ HILLS, M	T 4TH STREET N 56138	Т		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21390	Continued From pa	age 21	21390			
		maintaining awareness of of practice in infection control.				
	by: Based on observat review the facility f hygiene after cathe	tion, interview and document ailed to ensure proper hand eter cares was performed for 1 S) observed during activities of				
	Findings include:					
	Set (MDS) assess R26 required exter	hange in status Minimum Data ment dated 4/19/16, indicated nsive assistance of two staff for vities of daily living (ADL).				
	that R26 had Lewy	st revised on 4/26/16, indicated Body dementia, required ce with grooming and had a				
	and NA-H were ob cares for R26. NA then proceeded to catheter into a grad dumped the conter approximately 500 rinsed the containe R26's toilet. NA-G cares, requested N gloves from the ba soiled gloves used grabbed a set of gl on the wall and hat NA-H proceeded to	4 a.m. nursing assistant (NA)-G served performing morning -H applied clean gloves and drain urine from R26's urinary duate container. NA-H nts of the container containing milliliters of urine into the toilet, er and put it on the back of , who was assisting with R26's IA-H grab another set of throom. Still wearing the to empty the urine, NA-H loves from the full box mounted nded the clean gloves to NA-G. o apply R26's socks and shoes er soiled gloves. After				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED	
		00576	B. WING	B. WING		05/19/2016	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		10/2010	
	MORIAL HOME	505 EAS HILLS, M	T 4TH STREET	г			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
21390	Continued From pa	age 22	21390				
	as to whether she of washed her hands and before reachin additional clean glo	s cares, NA-H was interviewed changed her gloves and after emptying R1's catheter g into the glove box to remove oves and applying R26's icated she could not recall, but so.					
	director of nursing to be changing glov	n 5/18/16, at 10:01 a.m. the (DON) indicated staff needed ves and washing their hands s, "They get in-servicing on					
	Home, dated 3/29/ must be done any soiled, before and of the bathroom, at utensils or any use	Policy of the Tuff Memorial 16 indicated hand washing time your hands are visibly after eating, after personal use fter handling dirty linen, soiled d dressings, and with any in infection not killed by hand if.					
	administrator or de and procedures to techniques are follo re-educated and an ensure compliance	THOD OF CORRECTION: The signee could review policies ensure proper infection control owed. Facility staff could be n auditing system developed to auditing system developed to auditing system developed to be the results of the audit could quarterly quality assurance gs.					
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one					
21530	MN Rule 4658.131	0 A.B.C Drug Regimen Review	21530				
		nen of each resident must be nonthly by a pharmacist					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00576	B. WING		- 05/19/2016	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE	03/	19/2010
TUFF ME	MORIAL HOME		T 4TH STREET	г		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
21530	Continued From pa	age 23	21530			
nnesota D	This review must b Appendix N of the Surveyor Procedur Requirements in Le the Department of Health Care Finand This standard is in available through the system. It is not su B. The pharma irregularities to the and the attending p must be acted upo physician visit, or s pharmacist. For pu upon" means the a report and the sign of nursing services C. If the attend with the pharmaciss not provide adequa pharmacist believe being adversely aff refer the matter to if the medical direct physician does not must be referred for assessment and as by part 4658.0070. the medical direct must refer the matt assessment and as	by the Board of Pharmacy. be done in accordance with State Operations Manual, res for Pharmaceutical Service ong-Term Care, published by Health and Human Services, cing Administration, April 1992. acorporated by reference. It is he Minitex interlibrary loan ubject to frequent change. acist must report any director of nursing services ohysician, and these reports n by the time of the next sconer, if indicated by the urposes of this part, "acted acceptance or rejection of the ing or initialing by the director and the attending physician. ding physician does not concur at's recommendation, or does ate justification, and the se the resident's quality of life is fected, the pharmacist must the medical director for review ator is not the attending edical director determines that ician does not have adequate order and if the attending change the order, the matter or review to the quality ssurance committee required If the attending physician is or, the consulting pharmacist ter directly to the quality ssurance committee.				
ATE FOR	-		6899	FKO11	lf continuati	on sheet 24 c

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00576	B. WING		05/	05/19/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE			
	EMORIAL HOME	505 EAST HILLS, M	F 4TH STREET N 56138	г			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC [\]	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
	consulting pharmac consistent documen non-pharmacologic prior to administrati anti-anxiety medica the lack of docume effectiveness follow failed to identify the assess effectiveness medication (Remer reviewed for unnec Findings include: R48 was admitted t diagnoses including dementia with beha 4/12/16 signed physic	and document review the cist failed to identify the lack of intation of behaviors and al interventions attempted on of a PRN (as needed) ition (Ativan), failed to identify intation related to the ving Ativan administration and e need for a sleep study to as of an antidepressant on) for 1 of 5 residents (R48) essary medications.					
	for Mental Status (E severe cognitive im further indicated R4 assistance with all a exhibited rejection o behavior 1 to 3 day Review of the 4/12/	BIMS) score of "3", indicating pairment. The assessment 48 required extensive activities of daily living and of care and wandering s during the look back period. (16, signed physician orders					
	(milligram) po (by n anxiety; Give if agi looking for husband Start date of order-	ed an order for Ativan 1 mg nouth) every 4 hours PRN for tated or wanting to go home, d 3 times within 15 minutes; 3/3/16. re plan last revised 5/2/16,					
	included: PRN Ativ wanting to go home	an every 4 hours if agitated or e, looking for husband 3 times Try PRN wine, talking about					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00576	B. WING	B. WING		19/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
UFF ME	EMORIAL HOME		T 4TH STREET IN 56138	г		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530	sewing blankets, ta giving [Ativan]. Review of the elect (eMAR) revealed R Ativan 35 times from review of R48's eM indicated documen behavior exhibited attempted prior to a and the effectivene were only documen this time period. When interviewed of licensed practical m PRN Ativan was on non-pharmacologic effective. LPN-A co be implemented pri eMAR. LPN-A furth administered the m document in the "co description of R48's interventions attem When interviewed of registered nurse (R care plan included attempt prior to adm RN-B reviewed R44 surveyor and confir consistently docum	alking about gardening before tronic administration record R48 was administered PRN m 3/6/16 - 5/14/16. Further IAR and electronic record tation related to R48's and staff interventions administration of PRN Ativan ess following administration nted 15 out of 35 times during on 5/19/16, at 8:20 a.m. hurse (LPN)-A stated R48's ally given if cal interventions are not onfirmed the interventions to ior to use were listed on the her stated when PRN Ativan is nedication nurse is required to omments" section a s behavior and the apted prior to administration. on 5/18/16, at 2:21 p.m. RN)-B confirmed the eMAR and specific interventions to ministering R48's PRN Ativan. 8's PRN Ativan use with the rmed staff were not nenting R48's behavior and				
	RN-B also confirme consistently docum PRN Ativan and wo reflect this.	pted prior to administration. ed staff were also not penting the effectiveness of the puld expect documentation to on 5/19/16, at 9:25 a.m. the				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	EMORIAL HOME		T 4TH STREET	г		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
	documenting R48's attempted prior to a and in addition, the administered. When interviewed of director of nursing expectation when a Ativan would be to interventions attem and also staff shou Review of the unda Administration inclu (13.) The PRN me date, time, reason to the med and the sig Medication Aide] or with the charge nur Further review of R	d report shows med given, for giving, the effectiveness of gnature of TMA [Trained charge nurse. TMA's check se before giving a PRN med. 48's 4/12/16, signed physician				
	at HS (hour of slee 3/3/16. The diagno was: Alzheimer's D Review of the phys 3/3/16 indicated Re initiated "to hopeful overnight." Review not include evidence been conducted aff so the efficacy of the assessed.	order for Remeron 7.5 mg po p/bedtime) with a start date of osis indicated on the order Disease. ician progress note dated emeron 7.5 mg at HS would be ly induce some sedation of R48's medical record did se that a timely sleep study had the medication of the medication he medication could be on 5/18/16, at 2:21 p.m. RN-B				
	confirmed R48's Re 3/3/16 for sleep dis	emeron had been ordered on turbance. RN-B stated when dication is initiated nursing will				

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NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
TUFF ME	EMORIAL HOME		T 4TH STREE1 IN 56138	Г		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	age 27	21530			
	chart on the effectiveness 14 days after initiation to give the medication time to get into the resident's system. RN-B also stated the night staff will chart by exception related to sleep disturbance. RN-B confirmed a sleep study assessment related to the effectiveness of R48's Remeron was not conducted and should have been.					
	director of nursing confirmed that a sl	on 5/19/16, at 9:45 a.m. the (DON) eep study to determine efficacy ucted after initiation of R48's	/			
	consulting pharmac initiation of Remerc response related to pharmacist further assessment to dete	on 5/19/16, at 9:25 a.m. the cist stated within 5-7 days after on there should be some o sleep pattern. The confirmed a sleep study ermine effectiveness should ted within a week after the on.				
	regimen reviews da by the consulting p related to: inadequ response to PRN A documentation rela prior to PRN Ativar	ted on the monthly drug ated 3/15/16, 4/5/16 and 5/3/16 harmacist lacked any mention uate staff monitoring of R48's Ativan, inconsistent ated to interventions attempted or administration and the lack of effectiveness of Remeron after				
	administrator, direct consulting pharmac policies and procect medication usage.	THOD OF CORRECTION: The ctor of nursing (DON) and cist could review and revise dures for proper monitoring of The DON or designee, could non-pharmacological				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	- (X3) DATE SURVEY COMPLETED - 05/19/2016	
		00576	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S ⁻	TATE, ZIP CODE		
TUFF ME	EMORIAL HOME		T 4TH STREET	Г		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21530	Continued From pa	ige 28	21530			
	the quality assessn committee. An aud monitor the effectiv	entation and report back to nent and assurance it tool could be developed to eness of PRN medications. R CORRECTION: Twenty-one				
21540	MN Rule 4658.131 Usage; Monitoring	5 Subp. 2 Unnecessary Drug	21540			
	monitor each reside unnecessary drug i home's policies and pharmacist must re- resident's attending physician does not home's recomment adequate justification believes the reside adversely affected, matter to the medical director is the medical director is the medical director physician does not the order and if the change the order, to review to the Qualition (QAA) committee reside the attending physician does not the attend	g. A nursing home must ent's drug regimen for usage, based on the nursing d procedures, and the port any irregularity to the g physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist nt's quality of life is being the pharmacist must refer the cal director for review if the not the attending physician. If r determines that the attending have adequate justification for attending physician does not he matter must be referred for ty Assurance and Assessment equired by part 4658.0070. If ician is the medical director, macist shall refer the matter				
	by: Based on interview facility failed to con	ent is not met as evidenced and document review the sistently document behaviors logical interventions attempted				

STATEMEN	Dita Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00576	B. WING		05/19/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
TUFF ME	EMORIAL HOME		T 4TH STREET	r		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21540	prior to the adminis anti-anxiety medica document effective and failed to compl to determine effect medication (Remer reviewed for unnec Findings include: R48 was admitted diagnoses including dementia with beha 4/12/16 signed phy Review of the 14-d dated 4/3/16, revea for Mental Status (I severe cognitive im further indicated R4 assistance with all exhibited rejection behavior 1 to 3 day Review of the 4/12/ for R48 also reveal (milligram) po (by r anxiety; Give if agi looking for husband Start date of order- Review of R48's ca included: PRN Ativ wanting to go home within 15 minutes. sewing blankets, ta giving [Ativan].	stration of a PRN (as needed) ation (Ativan), failed to eness of Ativan administration lete a sleep study assessment iveness of an antidepressant ron) for 1 of 5 residents (R48) essary medications. to the facility 1/21/16, with g: Alzheimer's disease and avioral disturbance per the rsician orders. ay Minimum Data Set (MDS) aled R48 had a Brief Interview BIMS) score of "3", indicating spairment. The assessment 48 required extensive activities of daily living and of care and wandering rs during the look back period. (16, signed physician orders led an order for Ativan 1 mg nouth) every 4 hours PRN for itated or wanting to go home, d 3 times within 15 minutes; 3/3/16. are plan last revised 5/2/16, van every 4 hours if agitated or e, looking for husband 3 times Try PRN wine, talking about alking about gardening before	21540			
		tronic administration record 148 was administered PRN				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00576	B. WING		05/19/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
TUFF ME	EMORIAL HOME	505 EAST HILLS, MI	4TH STREE1 N 56138	Г		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21540	21540 Continued From page 30		21540			
	review of R48's eM indicated documen behavior exhibited attempted prior to a and the effectivene were only documen this time period. When interviewed of	m 3/6/16 - 5/14/16. Further AR and electronic record tation related to R48's and staff interventions administration of PRN Ativan ss following administration nted 15 out of 35 times during on 5/19/16, at 8:20 a.m. urse (LPN)-A stated R48's				
	PRN Ativan was on non-pharmacologic effective. LPN-A co be implemented pri eMAR. LPN-A furth administered the m document in the "co description of R48's	Ity given if al interventions are not onfirmed the interventions to for to use were listed on the her stated when PRN Ativan is redication nurse is required to comments" section a				
	registered nurse (F care plan included attempt prior to adr RN-B reviewed R44 surveyor and confir consistently docum interventions attem RN-B also confirme consistently docum	on 5/18/16, at 2:21 p.m. N)-B confirmed the eMAR and specific interventions to ninistering R48's PRN Ativan. B's PRN Ativan use with the med staff were not enting R48's behavior and pted prior to administration. ed staff were also not enting the effectiveness of the puld expect documentation to				
	consulting pharmac documenting R48's attempted prior to a	on 5/19/16, at 9:25 a.m. the cist confirmed staff should be behavior and interventions administration of PRN Ativan effectiveness of each dose				

			CONSTRUCTION		
OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
00576		B. WING		05/19/2016	
PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
MORIAL HOME		-	г		
SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)
		PREFIX TAG	CROSS-REFERENCED TO	THE APPROPRIATE	COMPLETE DATE
Continued From pa	age 31	21540			
director of nursing expectation when a Ativan would be to interventions attem and also staff shou Review of the unda Administration inclu (13.) The PRN me date, time, reason the med and the sig Medication Aide] or with the charge nur Further review of R orders revealed an at HS (hour of slee 3/3/16. The diagno was: Alzheimer's D Review of the phys 3/3/16 indicated Re initiated "to hopeful overnight." Review not include evidend	(DON) confirmed the administering R48's PRN document behaviors and pted prior to administration, ld document effectiveness. ated policy titled, Medication uded: d report shows med given, for giving, the effectiveness of gnature of TMA [Trained c charge nurse. TMA's check rse before giving a PRN med. 448's 4/12/16, signed physician order for Remeron 7.5 mg po p/bedtime) with a start date of osis indicated on the order Disease. ician progress note dated emeron 7.5 mg at HS would be lly induce some sedation of R48's medical record did ce that a timely sleep study hac				
so the efficacy of th assessed.	ne medication could be				
confirmed R48's Re 3/3/16 for sleep dis a psychotropic meet chart on the effective to give the medicate resident's system.	emeron had been ordered on turbance. RN-B stated when dication is initiated nursing will veness 14 days after initiation ion time to get into the RN-B also stated the night				
	ception related to sleep confirmed a sleep study				
	TOF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER MORIAL HOME SUMMARY STA (EACH DEFICIENC) REGULATORY OR L Continued From pa When interviewed d director of nursing expectation when a Ativan would be to interventions attem and also staff shou Review of the unda Administration inclu (13.) The PRN me date, time, reason the med and the sig Medication Aide] or with the charge nur Further review of F orders revealed an at HS (hour of slee 3/3/16. The diagno was: Alzheimer's I Review of the phys 3/3/16 indicated Re initiated "to hopeful overnight." Review not include evidend been conducted aff so the efficacy of th assessed. When interviewed a confirmed R48's Re 3/3/16 for sleep dis a psychotropic med chart on the effective to give the medicated resident's system. staff will chart by ex-	OF CORRECTION IDENTIFICATION NUMBER: 00576 00576 PROVIDER OR SUPPLIER STREET AI SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 31 When interviewed on 5/19/16, at 9:45 a.m. the director of nursing (DON) confirmed the expectation when administering R48's PRN Ativan would be to document behaviors and interventions attempted prior to administration, and also staff should document effectiveness. Review of the undated policy titled, Medication Administration included: (13.) The PRN med report shows med given, date, time, reason for giving, the effectiveness of the med and the signature of TMA [Trained Medication Aide] or charge nurse. TMA's check with the charge nurse before giving a PRN med. Further review of R48's 4/12/16, signed physician orders revealed an order for Remeron 7.5 mg po at HS (hour of sleep/bedtime) with a start date of 3/3/16. The diagnosis indicated on the order was: Alzheimer's Disease. Review of the physician progress note dated 3/3/16. The diagnosis indicated on the order was: Alzheimer's Disease. Review of the physician progress note dated 3/3/16 indicated Remeron 7.5 mg at HS would be initiated "to hopefully induce some sedation overnight." Review of R48's medical record did not include evidence that a timely sleep study hac been conducted after initiation of the medication so the efficacy of the medication could be assessed.	TO F DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING: DO576 PROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 31 21540 When interviewed on 5/19/16, at 9:45 a.m. the director of nursing (DON) confirmed the expectation when administering R48'S PRN Ativan would be to document behaviors and interventions attempted prior to administration, and also staff should document effectiveness. Review of the undated policy titled, Medication Adtinistration included: (13.) The PRN med report shows med given, date, time, reason for giving, the effectiveness of the med and the signature of TMA [Trained Medication Aide] or charge nurse. TMA's check with the charge nurse before giving a PRN med. Further review of R48's 4/12/16, signed physician orders revealed an order for Remeron 7.5 mg po at HS (hour of sleep/bedtime) with a start date of 3/3/16 indicated Remeron 7.5 mg at HS would be initiated "to hopefully induce some sedation overnight." Review of R48's medical record did not include evidence that a timely sleep study had been conducted after initiation of the medication so the efficacy of the medication could be assessed. When interviewed on 5/18/16, at 2:21 p.m. RN-B confirmed R48's Remeron had been ordered on 3/3/16 for sleep disturbance. RN-B stated when a psychotropic medication is initiated nursing will chart on the effectiveness 14 days after initiation to give the medication time to get into the resident's system. RN-B also stated the night staff will chart by exception related to sleep <	TO F DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIENCLIA DENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: 00576 B. WING *ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES (RACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OF LSC DENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF (EACH ODEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OF LSC DENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF (EACH ODEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OF LSC DENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF (EACH ODERSERFERNEE) Continued From page 31 21540 D PREFIX CHOSS-REFERENCED OF DEFICIENC Continued From page 31 21540 D PREFIX D PREFIX D PROVIDER'S PLAN OF (EACH ODERSENTIFY NG INFORMATION) D PREFIX Continued From page 31 21540 D PROVIDER'S PLAN OF (EACH ODERSENTIFY NG INFORMATION) D PROVIDER'S PLAN OF (EACH ODERSENTIFY NG INFORMATION) D PROVIDER'S PLAN OF (EACH ODERSENTIFY NG INFORMATION) When interviewed on 5/19/16, at 9:45 a.m. the director of nursing (DON) confirmed the expectation when administration, and also staff Should document effectiveness. N Review of the signature of TMA [Trained Medication Aide] or charge nurse. TMA'S check with the charge nurse before giving a PRN med. N Signa for the diagnosis indicated on the order was: Alzheimer's Disease. N Review of the physician progress note dated 3/3/16	TO FOR DEFICIENCIES (M) PROVIDERSUPPLIERCLATION NUMBER: ABULDING: (M) PROVIDERSUPPLIER ABULDING: (M) PROVIDERSUPPLIER 0576 PROVIDER OR SUPPLIER STREET ADDRESS. CITY. STATE, ZIP CODE (D) PROVIDERS PLAN OF CORRECTION (D) PROVIDERS PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION IEACH DEFICIENT MIST BE PRECEDED BY FULL ID PROVIDERS PLAN OF CORRECTION RECULATORY ON IS COENTERY IN STREET HECEDED BY FULL ID PROVIDERS PLAN OF CORRECTION SHOLID BE CREASED AT TAKE DEFICIENCY (M) SHOLID BE CREASED AT TAKE TO TAKE THE PRECEDED BY FULL IEACH OPARCTIVE ACTION SHOLID BE CREASED AT TAKE TO TAKE THE PRECEDED BY FULL ID PROVIDERS PLAN OF CORRECTION SHOLID BE CREASED AT TAKE TO TAKE THE PRECEDED BY FULL ID PROVIDERS PLAN OF CORRECTION SHOLID BE CREASED AT TAKE TO TAKE THE PRECEDED BY FULL ID PROVIDERS PLAN OF CORRECTION SHOLID BE CREASED AT TAKE TO TAKE TO TAKE THE PRECEDED BY FULL ID PROVIDERS PLAN OF CORRECTION SHOLID BE CREASED AT TAKE TO TAKE TO TAKE TO TAKE THE PRECEDED BY FULL ID PROVIDERS PLAN OF CORRECTION SHOLID BE CREASED AT TAKE TO

	NT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVI COMPLETED	
		00576	B. WING	B. WING		19/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
TUFF ME	EMORIAL HOME		T 4TH STREET IN 56138	Г		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21540	Continued From pa	ige 32	21540			
		d to the effectiveness of R48's conducted and should have				
	consulting pharmac initiation of Remerc response related to pharmacist further	on 5/19/16, at 9:25 a.m. the cist stated within 5-7 days after on there should be some o sleep pattern. The confirmed a sleep study I have been conducted within a ttion of Remeron.				
	director of nursing confirmed that a sle	on 5/19/16, at 9:45 a.m. the (DON) eep study to determine efficacy ucted after initiation of R48's	/			
	administrator, direct consulting pharmace policies and procect mediation usage. with the pharmacis	THOD OF CORRECTION: The stor of nursing (DON) and cist could review and revise dures for proper monitoring of The DON or designee, along t, could audit medication basis to ensure compliance.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
	MN Rule 4658.141 Housekeeping, Op	5 Subp. 2 Plant eration, & Maintenance	21685			
	including walls, floc systems, and equip continuous state of with regard to the h well-being of the re	plant. The physical plant, brs, ceilings, all furnishings, oment must be kept in a good repair and operation health, comfort, safety, and esidents according to a written be and repair program.				

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
00576		00576	B. WING		05/	19/2016
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	EMORIAL HOME	505 EAST HILLS, MI	4TH STREE	Т		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
21685	Continued From pa	age 33	21685			
	by: Based on observat review the facility fa were kept in workir	ent is not met as evidenced ion, interview and document ailed to ensure wheelchairs ng repair for 2 of 2 residents ed with torn wheelchair				
	Findings include:					
	assessment dated required total assis total assistance for	mum Data Set (MDS) 12/21/15, indicated he stance of two staff for transfers, locomotion in the wheelchair unable to be understood.				
	wheelchair was not left headrest, with a the tear. Maintena and confirmed it sh maintenance by nu overnight shift who saw them on a dail procedure for repo notebook at the nu nothing was on his wheelchair. M-A fu	on 5/18/16, at 1:42 p.m. R1's ted with a 6" ripped area on the exposed foam sticking out of nce (M)-A observed the area hould have been reported to arsing, probably by the cleaned the wheelchairs and y basis. M-A indicated he rting was to write it down on a rsing station and verified notebook regarding R1's arther indicated he did not a formal policy regarding this.				
	3/22/16, included a Status (BIMS) scor impaired cognition.	nimum Data Set (MDS) dated Brief Interview for Mental e of 3, indicating severely The MDS further indicated ed extensive assistance with all ring.				
	On 5/16/16, at 4:17 epartment of Health	7 p.m. R28 was observed				
TE FOR	-		⁶⁸⁹⁹ QI	FKO11	If continuati	on sheet 34 d

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00576	B. WING		05/19/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
TUFF MI	EMORIAL HOME	505 EAS ⁻ HILLS, M	F 4TH STREE ⁻ N 56138	Т		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21685	Continued From pa	age 34	21685			
nnesota D	armrests on the w/with jagged edges a armrest exposing the The right armrest a on the top of the ar- missing exposing the When interviewed of maintenance super- maintenance issue write them down or- nurses station. MS list several times the working. MS stated with R28's w/c as h- verbally by staff non- maintenance list. M- list located on a clip and confirmed R28 been added to the proceeded to R28's acknowledged that replacing and confi- cause skin tearing cleanable surface. the staff to let him H does not audit the w concerns. MS furth responsible for clean have identified and armrests to his atter SUGGESTED MET administrator, direct designee could won- maintenance to dev- to ensure wheelcha and clean appearant	chair (w/c) in her room. The c were observed with tears along the outer edge of each he foam padding underneath. Iso had a round circular area mrest where the vinyl was he foam padding underneath. on 5/18/16, at 9:46 a.m. the rvisor (MS) stated when s are identified, staff are to n a clipboard located at the 6 further stated he checks the iroughout the day when d being unaware of any issues he had not been informed r had it been identified on his MS and surveyor observed the oboard at the nurses station l's torn w/c armrests had not list. MS and surveyor s room. Upon observation, MS R28's w/c armrests need rmed the jagged edges could as well as not being a MS stated he depended upon know about w/c issues as he w/c's for maintenance her stated the night staff are aning of the w/c's and should brought R28's torn w/c ention.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVE COMPLETED	
		00576	B. WING		05/	19/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
UFF ME	MORIAL HOME		T 4TH STREET IN 56138	г		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
21685	Continued From pa	ge 35	21685			
	ongoing compliance	е.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21910	MN St. Statute 144 Residents of HC Fa	.651 Subd. 25 Patients & ac.Bill of Rights	21910			
	residents may man affairs, or shall be g accounting of finan- behalf if they delega	ial affairs. Competent age their personal financial given at least a quarterly cial transactions on their ate this responsibility in e laws of Minnesota to the of time.				
	by: Based on interview facility failed to prov residents and/or the 45 residents (R46, R3, R11, R43, R5,	ent is not met as evidenced and documentation review the vide quarterly statements to e legal representative for 16 of R2, R16, R38, R1, R40, R41, R28, R18, R22, R29, R27) nds were managed by the				
	Findings include:					
	stated resident has	a.m. R46's family member a personal fund account with never received a quarterly y balance.				
	account was verifie receptionist (R)-B.	p.m. R46's personal fund d and reviewed with facility It showed a balance of \$50.00 ts or credits were noted on the				

	ota Department of He	ealth	1			
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00576	B. WING		05/19/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
TUFF ME	EMORIAL HOME	505 EAS ⁻ HILLS, M	T 4TH STREET	r		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21910	Continued From pa	ge 36	21910			
	stated she was in c accounts and main verified all residents Account Form allow their personal funds confirmed they wou the resident and/or been activity in the did not send quarte she was unaware c quarterly personal f residents/responsit (R46, R2, R16, R38 R43, R5, R28, R18 fund accounts with quarterly statement					
	requested but not p SUGGESTED MET Administrator or de and procedures relation of resident account statements are pro-	personal fund accounts was provided. THOD OF CORRECTION: The signee could create policies ated to financial management s to ensure quarterly vided to residents. Quality ee could audit for compliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21980	MN St. Statute 626 Maltreatment of Vu	.557 Subd. 3 Reporting - Inerable Adults	21980			
	reporter who has re vulnerable adult is l	of report. (a) A mandated eason to believe that a being or has been maltreated, dge that a vulnerable adult				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00576	B. WING	0 5/ ⁻	19/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STATE, ZIP CODE		
		505 EAS	T 4TH STREET		
	MORIAL HOME	HILLS, M	N 56138		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH COR	ER'S PLAN OF CORRECTION IRECTIVE ACTION SHOULD BE IRENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
21980	Continued From pa	ge 37	21980		
	has sustained a phy reasonably explained information to the co- individual is a vulner the individual is a dur reporter is not requir maltreatment of the to admission, unless (1) the individual wa another facility and believe the vulnerate previous facility; or (2) the reporter k that the individual is in section 626.5572 (b) A person not provisions of this se as described above (c) Nothing in this known or suspected knows or has reason been made to the c (d) Nothing in this reporter from also r agency. (e) A mandated r reason to believe th 626.5572, subdivisi (5), occurred must r subdivision. If the r time believes that a agency will determine the reported error w the criteria under se 17, paragraph (c), occurred must r	ysical injury which is not ed shall immediately report the ommon entry point. If an rable adult solely because nitted to a facility, a mandated ired to report suspected individual that occurred prior s: as admitted to the facility from the reporter has reason to ble adult was maltreated in the nows or has reason to believe a vulnerable adult as defined by subdivision 21, clause (4). required to report under the ection may voluntarily report as section requires a report of d maltreatment, if the reporter on to know that a report has			

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00576	B. WING		- 05/19/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S ⁻	TATE, ZIP CODE		
TUFF ME	EMORIAL HOME		T 4TH STREET	r		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21980	Continued From pa	ge 38	21980			
	(5). The lead ager	ion 17, paragraph (c), clause ncy shall consider this naking an initial disposition of bdivision 9c.				
	This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate and to immediately report injuries of unknown origin and/or allegations of neglect to the State Agency (SA) and administrator for 2 of 5 incidents (R28 & R22) reviewed.					
	investigation, imme administrator and to injury of unknown o according to the ph which included: der	v their policy related to the ediate reporting to the o the SA when R28 had an origin. R28 had diagnoses ysician orders dated 4/7/16, mentia, major depression, and Alzheimer's disease.				
	assessment, dated Brief Interview for N 3 which indicated s The MDS further id	imum Data Set (MDS) 3/22/16, identified R28 had a Aental Status (BIMS) score of evere cognitive impairment. entified R28 required ce of one staff with all activities s).				
	noted on 12/25/15, injury. The details of incident report, date indicated R28's ala staff and when staff found lying on the f	cility incident reports it was R28 had a fall with significant of the fall documented on the ed 12/25/15, at 10:04 p.m. rm was heard sounding by f entered the room, R28 was loor in her room on her right recliner. R28's head was				

Output B. WING Optimize NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE TUFF MEMORIAL HOME SOE ASS 14TH STREET IVAN IO SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 39 21980 Continued From page 39 ID Courtent of blood" under her head. Documentation indicated R28 had blood noted in her hair and running down the side of her face. R28 also had a large lump on her right hand measuring 9 cm by 3 cm, with the skin rolled back and a "large" amount of blood cording from the skin tear. The incident documentation further identified R28 had a commode beside her bed and her personal alarm was sounding. There was a pool of urine noted on the floor by her feet and it was soiled. R28 was transported to the hospital for treatment via personal automobile with a family member. R28 was transported to the the face on lump as needed for five (5) days, and follow-up with her provider.	STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
SDE SAST 4TH STREET HILLS, MN 56133 (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 CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY 21980 Continued From page 39 21980 located at the edge of the recliner by the end table in R28's room. R28 was observed by staff to have a "pool of blood" under her head. Documentation indicated R28 had blood noted in her hair and running down the side of her face. R28 also had a large lump on her right temple region that measured 4.5 centimeters (cm) by 7.5 cm with a laceration in the center of the lump. A skin tear Skin tear The incident documentation further identified R28 had a commode beside her bed and her personal alarm was sounding. There was a pool of urine noted on the floor and R28 had lincontinent stool running down her leg. R28's biref (incontinent pad) was also noted lying on the floor by her feet and it was soiled. R28 was transported to the hospital for treatment via personal automobile with a family member. R28 was transported back to the facility on 12/26/15, at 1:15 a.m. via ambulance. Upon return to facility, physician orders included: continue current medications, place ice on lump as needed for five (5) days, and follow-up with ther Here is the face is the face is the face is continent stool running down her (6) days, and follow-up with ther			00576	B. WING		05/	19/2016
TUPEF MEMORIAL HOME HILLS, MN 56138 (%) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BUT FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MIST BE PRECEDED DE VILL REGULATORY OR LSC IDENTIFYING INFORMATION) 21980 Continued From page 39 located at the edge of the recliner by the end table in R28's room. R28 was observed by staff to have a "pool of blood" under her head. Documentation indicated R28 had blood noted in her hair and running down the side of her face. R28 also had a large lump on her right temple region that measured 4.5 centimeters (cm) by 7.5 cm with a laceration in the center of the lump. A skin tear was noted on the top of her right hand measuring 9 cm by 3 cm, with the skin rolled back and a "large" amount of blood coming from the skin tear. The incident documentation further identified R28 had a commode beside her bed and her personal alarm was sounding. There was a pool of urine noted on the floor and R28 had incontinent pad) was also noted lying on the floor by her feet and it was soiled. R28 was transported to the hospital for treatment via personal automobile with a family member. R28 was transported back to the facility on 12/26/15, at 1:15 a.m. via ambulance. Upon return to facility, physician orders included: continue current medications, place ice on lump as needed for five (5) days, and follow-up with ther	NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
PREFIX TAG IEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG IEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 21980 Continued From page 39 21980 located at the edge of the recliner by the end table in R28's room. R28 was observed by staff to have a "pool of blood" under her head. Documentation indicated R28 had blood noted in her hair and running down the side of her face. R28 also had a large lump on her right temple region that measured 4.5 centimeters (cm) by 7.5 cm with a laceration in the center of the lump. A skin tear was noted on the top of her right hand measuring 9 cm by 3 cm, with the skin rolled back and a "large" amount of blood coming from the skin tear. The incident documentation further identified R28 had a commode beside her bed and her personal alarm was sounding. There was a pool of urine noted on the floor and R28 had incontinent stool running down her leg. R28's brief (incontinent pad) was also noted lying on the floor by her feet and it was soiled. R28 was transported to the hospital for treatment via personal automobile with a family member. R28 was transported to the hospital for treatment via personal automobile with a family member. R28 was transported to the hospital for treatment via personal automobile with a family member. R28 was transported to the hospital for treatment via personal automobile with a family member. R28 was transported back to the facility on 12/26/15, at 1:15 a.m. via ambulance. Upon return to facility, physician orders included: continue current medications, place ice on lump as needed for five (5) days, and follow-up with her	TUFF MI	EMORIAL HOME		-	r		
located at the edge of the recliner by the end table in R28's room. R28 was observed by staff to have a "pool of blood" under her head. Documentation indicated R28 had blood noted in her hair and running down the side of her face. R28 also had a large lump on her right temple region that measured 4.5 centimeters (cm) by 7.5 cm with a laceration in the center of the lump. A skin tear was noted on the top of her right hand measuring 9 cm by 3 cm, with the skin rolled back and a "large" amount of blood coming from the skin tear. The incident documentation further identified R28 had a commode beside her bed and her personal alarm was sounding. There was a pool of urine noted on the floor and R28 had incontinent stool running down her leg. R28's brief (incontinent pad) was also noted lying on the floor by her feet and it was soiled. R28 was transported to the hospital for treatment via personal automobile with a family member. R28 was transported back to the facility on 12/26/15, at 1:15 a.m. via ambulance. Upon return to facility, physician orders included: continue current medications, place ice on lump as needed for five (5) days, and follow-up with her	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
When interviewed on 5/19/16, at 9:36 a.m. the director of nursing (DON) verified the facility had not reported to the State agency nor investigated this incident. The facility did not implement their Vulnerable Adult policy which required an investigation and immediate notification of the administrator and	21980	located at the edge table in R28's room have a "pool of bloo Documentation ind her hair and runnin R28 also had a larg region that measur cm with a laceratio skin tear was noted measuring 9 cm by back and a "large" the skin tear. The incident docum had a commode be alarm was soundin noted on the floor a running down her le pad) was also note and it was soiled. R28 was transported 12/26/15, at 1:15 a return to facility, ph continue current m as needed for five provider. When interviewed director of nursing not reported to the this incident. The facility did not Adult policy which in	e of the recliner by the end h. R28 was observed by staff to od" under her head. icated R28 had blood noted in g down the side of her face. ge lump on her right temple ed 4.5 centimeters (cm) by 7.5 n in the center of the lump. A d on the top of her right hand '3 cm, with the skin rolled amount of blood coming from nentation further identified R28 eside her bed and her personal g. There was a pool of urine and R28 had incontinent stool eg. R28's brief (incontinent 'd lying on the floor by her feet ed to the hospital for treatment tobile with a family member. ed back to the facility on .m. via ambulance. Upon hysician orders included: edications, place ice on lump (5) days, and follow-up with her on 5/19/16, at 9:36 a.m. the (DON) verified the facility had State agency nor investigated implement their Vulnerable required an investigation and				

STATEMEN	Dita Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00576	B. WING	B. WING		19/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE		
TUFF ME	EMORIAL HOME		T 4TH STREET IN 56138	Г		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21980	Continued From pa	age 40	21980			
	disease, dementia	s that included: Alzheimer's with behavioral disturbance, osteoarthritis per the signed dated 4/12/16.				
	assessment, dated Brief Interview for M 3, which indicated The MDS further id	num Data Set (MDS) I 4/3/16, identified R48 had a Mental Status (BIMS) score of severe cognitive impairment. Ientified R48 required ce of one staff with all activities 's).	3			
	noted on 3/17/16, F with significant inju identified on the ind 1:35 a.m. indicated 3/17/16, at 11:55 a. help and upon ente lying on left side ho area. Documentati excruciating pain w bending her right k the hospital on 3/18	48's incident reports it was R48 had an unwitnessed fall ry. The details of the fall cident report dated 3/18/16, at the incident occurred on .m. Staff heard R48 call for ering the room observed R48 olding her right buttock thigh ion indicated R48 verbalized <i>i</i> th facial grimacing when nee. R48 was transferred to 8/16, at 12:48 a.m. via luation and treatment.				
	2:48 a.m. indicated hospital. The subs 3/18/16, at 11:30 a identified R48 had	rogress note dated 3/18/16, at I R48 had been admitted to the sequent progress note dated .m. indicated a CT scan a fracture to the right pelvis. e facility on 3/21/16.				
	DON confirmed the fracture was not re the care plan was b	on 5/18/16, at 3:30 p.m. the e 3/17/16, fall resulting in pelvic ported as it was determined being followed. DON further vas unwitnessed and R48 was				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED	
		00576	B. WING			19/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
TUFF MI	EMORIAL HOME		T 4TH STREET IN 56138			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21980	Continued From pa	age 41	21980			
	unable to tell staff t the fall.	he circumstances related to				
	Protection Plan rev following: (12.) INJURIES Of injury that meets bo (1) If the source of person or the source reasonably explain the injury is suspici the injury or the loc number of injuries of point in time or the This includes an inj	implement their Vulnerable rised 7/1/15, which included the F UNKNOWN ORIGIN: An oth the following conditions: injury was not observed by any ce of the injury could not be ed by the resident, AND, (2) if ous because of the extent of ation of the injury or the observed at one particular incidence of injuries over time. jury to a resident resulting in skin tears, lacerations, welts,	/			
	possible from the ti that the incident oc after discovery of th aware of a situation emergency, medica services should be	LY: means as soon as ime of the initial knowledge curred, has been received or he incident. If staff becomes n or incident where police, al services or protective involved ASAP, the facility t and then report to the MDH				
	(A.) Staff is to notif concerning any obs abuse, neglect, inv maltreatment/mistr or misappropriation	eatment, unknown injury event of personal property y with any patterns, trends or ut interviewing the				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED	
		B. WING		05/	05/19/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
	EMORIAL HOME	505 EAS HILLS, M	T 4TH STREET	Г		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21980	Continued From pa	age 42	21980			
	administrator or de education and train of staff, to ensure in allegations of abus and reported to the administrator imme audited and the res	THOD OF CORRECTION: The signee could provide ing regarding responsibilities njuries of unknown origin and e are thoroughly investigated State agency and ediately. All incidents could be sults reported to the quality see for further review.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21995	MN St. Statute 626 Maltreatment of Vu	.557 Subd. 4a Reporting - Inerable Adults	21995			
	(a) Each facility sh ongoing written pro applicable licensing of suspected maltre facility has an intern mandated reporter requirements of this internally. Howeve	I reporting of maltreatment. all establish and enforce an ocedure in compliance with g rules to ensure that all cases eatment are reported. If a nal reporting procedure, a may meet the reporting s section by reporting r, the facility remains nplying with the immediate ents of this section.				
	by: Based on interview facility failed to imp policy to ensure the reporting of allegati unknown origin to t	ent is not met as evidenced and document review the lement their Vulnerable Adult investigation and immediate ions of abuse and/or injuries of he administrator and to the for 2 of 5 resident incidents ved.				
	Findings include:					

STATE FORM

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
00576		00576	B. WING		- 05/19/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE	•	
	EMORIAL HOME	505 EAS ⁻ HILLS, M	T 4TH STREET N 56138	r		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21995	Continued From pa	age 43	21995			
	Protection Plan rev following: (12.) INJURIES OI injury that meets bo (1) If the source of person or the source reasonably explained the injury is suspici the injury or the loc number of injuries of point in time or the This includes an inj	implement their Vulnerable ised 7/1/15, which included the F UNKNOWN ORIGIN: An oth the following conditions: injury was not observed by any ce of the injury could not be ed by the resident, AND, (2) if ous because of the extent of ation of the injury or the observed at one particular incidence of injuries over time. jury to a resident resulting in skin tears, lacerations, welts,	,			
	possible from the ti that the incident oc after discovery of th aware of a situation emergency, medica services should be	LY: means as soon as me of the initial knowledge curred, has been received or ne incident. If staff becomes n or incident where police, al services or protective involved ASAP, the facility and then report to the MDH				
	(A.) Staff is to notif concerning any obs abuse, neglect, inve maltreatment/mistr or misappropriation	eatment, unknown injury event of personal property with any patterns, trends or ut interviewing the				
	investigation, imme	v their policy related to the ediate reporting to the o the State agency when R28				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00576				(X3) DATE SURVEY COMPLETED		
		00576	B. WING		05/	19/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
TUFF ME	EMORIAL HOME	505 EAST HILLS, M	74TH STREET N 56138	Г		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21995	had an injury of unl diagnoses accordir dated 4/7/16, which depression, psycho disease. R28's quarterly Min	age 44 known origin. R28 had ng to the physician orders n included: dementia, major osis, anxiety and Alzheimer's nimum Data Set (MDS) 3/22/16, identified R28 had a	21995			
	3 which indicated s The MDS further id extensive assistant of daily living (ADL' During review of fa	cility incident reports it was				
	injury. The details of incident report, data indicated R28's ala staff and when staff found lying on the f side in front of her located at the edge table in R28's room have a "pool of bloo Documentation ind her hair and runnin R28 also had a larg region that measur cm with a laceration skin tear was noted measuring 9 cm by	R28 had a fall with significant of the fall documented on the ed 12/25/15, at 10:04 p.m. rm was heard sounding by if entered the room, R28 was floor in her room on her right recliner. R28's head was e of the recliner by the end h. R28 was observed by staff to od" under her head. icated R28 had blood noted in g down the side of her face. ge lump on her right temple ed 4.5 centimeters (cm) by 7.5 n in the center of the lump. A d on the top of her right hand y 3 cm, with the skin rolled amount of blood coming from				
	The incident docun had a commode be alarm was soundin noted on the floor a	nentation further identified R28 eside her bed and her personal g. There was a pool of urine and R28 had incontinent stool eg. R28's brief (incontinent				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00576		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00576	B. WING			19/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
TUFF ME	EMORIAL HOME		T 4TH STREET IN 56138	г		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21995	Continued From pa	age 45	21995			
	pad) was also note and it was soiled.	d lying on the floor by her feet				
	via personal autom R28 was transporte 12/26/15, at 1:15 a return to facility, ph continue current m	ed to the hospital for treatment nobile with a family member. ed back to the facility on .m. via ambulance. Upon hysician orders included: edications, place ice on lump (5) days, and follow-up with he				
	director of nursing	on 5/19/16, at 9:36 a.m. the (DON) verified the facility had State agency nor investigated				
	Adult policy which i immediate notificat	implement their Vulnerable required an investigation and tion of the administrator and hen R48 experienced an injury	/			
	disease, dementia	s that included: Alzheimer's with behavioral disturbance, osteoarthritis per the signed dated 4/12/16.				
	assessment, dated Brief Interview for N 3, which indicated The MDS further id	num Data Set (MDS) I 4/3/16, identified R48 had a Mental Status (BIMS) score of severe cognitive impairment. Ientified R48 required ce of one staff with all activities 's).	;			
	noted on 3/17/16, F with significant inju	48's incident reports it was R48 had an unwitnessed fall ry. The details of the fall cident report dated 3/18/16, at				

STATEMENT OF DEFICIENCIES () AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00576	B. WING		05/19/2016		
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		10/2010	
TUFF MI	EMORIAL HOME		T 4TH STREET IN 56138	r			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21995	1:35 a.m. indicated 3/17/16, at 11:55 a. help and upon entel lying on left side ho area. Documentati excruciating pain w bending her right kr the hospital on 3/18 ambulance for eval Review of R48's pro- 2:48 a.m. indicated hospital. The subs- 3/18/16, at 11:30 a. identified R48 had a R48 returned to the When interviewed of DON confirmed the fracture was not rep the care plan was b confirmed the fall w unable to tell staff the the fall. SUGGESTED MET administrator or des education and train of staff, to ensure ir allegations of abuse and reported to the administrator imme audited and the res assurance committ	the incident occurred on m. Staff heard R48 call for ring the room observed R48 lding her right buttock thigh on indicated R48 verbalized ith facial grimacing when nee. R48 was transferred to 8/16, at 12:48 a.m. via uation and treatment. ogress note dated 3/18/16, at R48 had been admitted to the equent progress note dated m. indicated a CT scan a fracture to the right pelvis. e facility on 3/21/16. on 5/18/16, at 3:30 p.m. the 9 3/17/16, fall resulting in pelvic ported as it was determined being followed. DON further vas unwitnessed and R48 was he circumstances related to THOD OF CORRECTION: The signee could provide ing regarding responsibilities njuries of unknown origin and e are thoroughly investigated	;				