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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QFKO

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00576

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245548**

2. STATE VENDOR OR MEDICAID NO. (L2) **230743000**

3. NAME AND ADDRESS OF FACILITY
(L3) **TUFF MEMORIAL HOME**
(L4) **505 EAST 4TH STREET**
(L5) **HILLS, MN** (L6) **56138**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **8/5/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Joseph Garvey, HFE NE II 08/10/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 9/1/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **03/01/1991** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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.

Sincerely,

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

MDH
Minnesota Department of Health

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

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,

Kamala Fiske-Downing

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245548 (Y1)	A. Building B. Wing (Y2)	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 qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 08/05/2016	ID Prefix F0312 Reg. # 483.25(a)(3) LSC	Correction Completed 08/05/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)** KS/kfd	**DATE** 8/10/2016	**SIGNATURE OF SURVEYOR** 22113	**DATE** 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? ☐ **YES** ☐ **NO**			

MDH
Minnesota Department of Health

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,

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

cc: Program Assurance Unit
Penalty Assessment Deposit Staff

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
00576 Y1	Y2	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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20565 Reg. # MN Rule 4658.0405 Subp. 3 LSC	Correction Completed 08/05/2016	ID Prefix 20920 Reg. # MN Rule 4658.0525 Subp. 6 B LSC	Correction Completed 08/05/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) KS/kfd	DATE 8/10/2016	SIGNATURE OF SURVEYOR 22113	DATE 8/5/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
5/19/2016	

 EVENT ID: QFKO13

STATE FORM: REVISIT REPORT (11/06)

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QFKO

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00576

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245548**

2. STATE VENDOR OR MEDICAID NO. (L2) **230743000**

3. NAME AND ADDRESS OF FACILITY
(L3) **TUFF MEMORIAL HOME**
(L4) **505 EAST 4TH STREET**
(L5) **HILLS, MN** (L6) **56138**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **07/07/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Wendy Buckholz, HFE NE II 8/2/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 8/26/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **03/01/1991** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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 https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

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

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: Kathryn.serie@state.mn.us
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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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:

KMS approved POC 8/2/16

F282 & F312

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 3rd, 2016.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	R 07/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite Post Certification Revisit (PCR) was completed on 7/6/16 and 7/7/16, to follow up on deficiencies issued during a recertification survey exited on 5/19/16. As a result, the following deficiencies were uncorrected: F282 and F312. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form.	{F 000}		
{F 282} SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to follow the plan of care related to oral care for 2 of 4 residents (R1, R26) reviewed for activities of daily living/oral care. Findings include: R1's quarterly Minimum Data Set (MDS) assessment dated 12/21/15, indicated he required total assistance of two staff for grooming. R1's care plan dated 6/14/16, indicated R1 had upper denture which staff leave out due to poor fit and staff were to brush his lower teeth. R1's current Nursing Assistant assignment sheet, indicated R1's teeth should be brushed.	{F 282}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 282}	Continued From page 1 During observation on 7/7/16, at 7:37 a.m. nursing assistants (NA)-F and NA-J performed personal cares for R1. NA-F used a toothette and swabbed once around R1's mouth. When questioned whether R1 had teeth, NA-F replied that he had upper dentures but staff do not place them in the mouth since they don't fit and R1 can eat better without them. NA-F did not brush R1's lower teeth when observed. During interview on 7/7/16, at 12:01 p.m. NA-J stated R1's dentures don't fit anymore because he lost so much weight and consequently staff don't put them in his mouth anymore. She also stated he had lower teeth but "we don't brush them, they just get swabbed, that's what we were told to do." 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	{F 282}		

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TUFF MEMORIAL HOME	**505 EAST 4TH STREET HILLS, MN 56138**

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{F 282}	Continued From page 2 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 transferring him into his wheelchair. Once transferred, the NA's assisted R26 with washing his face and combing hair. R26 was then wheeled to the lounge area to watch television prior to breakfast. It was observed that neither NA provided oral hygiene for R26 during morning cares. When interviewed on 7/07/16, at 9:00 a.m. NA-J confirmed she had not provided oral care for R26 during or prior to the observation of AM cares. NA-F confirmed placing R26's upper denture in his mouth prior to the surveyor entering the room. NA-F stated she had brushed R26's upper denture prior to placement and further stated she also swabbed R26's mouth with a toothette wetted with water prior to the placement of the upper denture. NA-J confirmed R26 had natural lower teeth present and verified she did not brush the R26's lower teeth with a toothbrush. When interviewed on 7/07/16, at 11:04 a.m. the director of nursing (DON) confirmed R26's lower natural teeth should be brushed with a toothbrush and toothpaste during morning and bedtime cares per the plan of care. The Tuff Memorial Home Care Plan policy, last updated 4/22/16, indicated each care plan would be reviewed every 90 days as required by law.	{F 282}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 312} SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide oral care for 2 of 4 residents (R1, R26) reviewed for activities of daily living/oral care. Findings include: R1's quarterly Minimum Data Set (MDS) assessment dated 12/21/15, indicated he required total assistance of two staff for grooming. An oral/dental care area assessment did not trigger for R1 during the prior full MDS assessment. R1's care plan dated 6/14/16, indicated R1 had upper denture which staff leave out due to poor fit and staff were to brush his lower teeth. R1's current Nursing Assistant assignment sheet, indicated R1's teeth should be brushed. R1's Mouth/Throat/Neck/Speech and Communication note dated 6/22/16, indicated R1 had teeth in the lower gum line in very poor condition, many fillings and wore dentures that were loose. A care note from 7/30/15, dental exam identified that R1's teeth had decay, a large amount of	{F 312}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 312}	Continued From page 4	{F 312}		

plaque at the gumline and should have his teeth brushed 2 times per day.

During observation on 7/7/16, at 7:37 a.m. nursing assistants (NA)-F and NA-J performed personal cares for R1. NA-F used a toothette and swabbed once around R1's mouth. When questioned whether R1 had teeth, NA-F replied that he had upper dentures but staff do not place them in the mouth since they don't fit and R1 can eat better without them. NA-F did not brush R1's lower teeth.

During interview on 7/7/16, at 12:01 p.m. NA-J stated R1's dentures don't fit anymore because he lost so much weight and consequently staff don't put them in his mouth anymore. She also stated he had bottom teeth but "we don't brush them they just get swabbed, that's what we were told to do."

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 just swabbed with a toothette.

R26's significant change in status MDS assessment dated 4/19/16, indicated R26 required extensive assistance of two staff for grooming. The Care Area Assessment (CAA) for oral/dental status did not trigger.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 312}	Continued From page 5 [dentures] at hour of sleep (HS) in the denture cup. The care plan also indicated R26's natural teeth should be brushed with AM and PM 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 transferring him into his wheelchair. Once transferred, the NA's assisted R26 with washing his face and combing hair. R26 was then wheeled to the lounge area to watch television prior to breakfast. It was observed that neither NA provided oral hygiene for R26 during morning cares. When interviewed on 7/07/16, at 9:00 a.m. NA-J confirmed she had not provided oral care for R26 during or prior to the observation of AM cares. NA-F confirmed placing R26's upper denture in his mouth prior to the surveyor entering the room. NA-F stated she had brushed R26's upper denture prior to placement and further stated she also swabbed R26's mouth with a toothette wetted with water prior to the placement of the upper denture. NA-J confirmed R26 had natural lower teeth present and verified she did not brush the R26's bottom teeth with a toothbrush. When interviewed on 7/07/16, at 11:04 a.m. the director of nursing (DON) confirmed R26's lower natural teeth should be brushed with a toothbrush and toothpaste. The DON further confirmed per the toothbrushing audits she had conducted, that	{F 312}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{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}		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245548 Y1	A. Building 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 qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0159	Correction	ID Prefix	F0225	Correction	ID Prefix	F0226	Correction
Reg. #	483.10(c)(2)-(5)	Completed	Reg. #	483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg. #	483.13(c)	Completed
LSC		06/28/2016	LSC		06/28/2016	LSC		06/28/2016
ID Prefix	F0280	Correction	ID Prefix	F0309	Correction	ID Prefix	F0329	Correction
Reg. #	483.20(d)(3), 483.10(k)(2)	Completed	Reg. #	483.25	Completed	Reg. #	483.25(l)	Completed
LSC		06/28/2016	LSC		06/28/2016	LSC		06/28/2016
ID Prefix	F0428	Correction	ID Prefix	F0441	Correction	ID Prefix	F0465	Correction
Reg. #	483.60(c)	Completed	Reg. #	483.65	Completed	Reg. #	483.70(h)	Completed
LSC		06/28/2016	LSC		06/28/2016	LSC		06/28/2016
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		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	KS/kfd	7/26/2016	31767	7/7/2016
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? ☐ **YES** ☐ **NO**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245548	A. Building 01 - MAIN BUILDING 01 B. Wing	7/5/2016

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
ID Prefix Reg. # NFPA 101 LSC K0025	Correction Completed 05/23/2016	ID Prefix Reg. # NFPA 101 LSC K0147	Correction Completed 05/23/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 7/26/2016	SIGNATURE OF SURVEYOR 35482	DATE 7/5/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
5/17/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

Minnesota Department of Health

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,

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

cc: Program Assurance Unit
Penalty Assessment Deposit Staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00576	A. BUILDING: _____ B. WING _____	R 07/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	**505 EAST 4TH STREET HILLS, MN 56138**

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{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: An onsite follow-up visit was completed on 07/06/16 and 07/07/16. During this onsite visit it was determined that the following corrections orders/s # 0565, #0920 were NOT corrected. This uncorrected order/s will remain in effect and will be reviewed at the next onsite visit. Also uncorrected order/s will be reviewed for possible	{2 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

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{2 000}	Continued From page 1 penalty assessment/s.	{2 000}	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 which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
{2 565}	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced	{2 565}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00576	A. BUILDING: _____ B. WING _____	R 07/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 565}	Continued From page 2 by: "Uncorrected based on the following findings. The original licensing order issued on 5/19 /16 will remain in effect. Penalty assessment issued." Based on observation, interview, and document review the facility failed to follow the plan of care related to oral care for 2 of 4 residents (R1, R26) reviewed for activities of daily living/oral care. Findings include: R1's quarterly Minimum Data Set (MDS) assessment dated 12/21/15, indicated he required total assistance of two staff for grooming. R1's care plan dated 6/14/16, indicated R1 had upper denture which staff leave out due to poor fit and staff were to brush his lower teeth. R1's current Nursing Assistant assignment sheet, indicated R1's teeth should be brushed. During observation on 7/7/16, at 7:37 a.m. nursing assistants (NA)-F and NA-J performed personal cares for R1. NA-F used a toothette and swabbed once around R1's mouth. When questioned whether R1 had teeth, NA-F replied that he had upper dentures but staff do not place them in the mouth since they don't fit and R1 can eat better without them. NA-F did not brush R1's lower teeth when observed. During interview on 7/7/16, at 12:01 p.m. NA-J stated R1's dentures don't fit anymore because he lost so much weight and consequently staff don't put them in his mouth anymore. She also stated he had lower teeth but "we don't brush them, they just get swabbed, that's what we were told to do."	{2 565}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00576	A. BUILDING: _____ B. WING _____	R 07/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 565}	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 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 transferring him into his wheelchair. Once transferred, the NA's assisted R26 with washing his face and combing hair. R26 was then wheeled to the lounge area to watch television prior to breakfast. It was observed that neither NA provided oral hygiene for R26 during morning cares. When interviewed on 7/07/16, at 9:00 a.m. NA-J confirmed she had not provided oral care for R26	{2 565}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00576	A. BUILDING: _____ B. WING _____	R 07/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 565}	Continued From page 4 during or prior to the observation of AM cares. NA-F confirmed placing R26's upper denture in his mouth prior to the surveyor entering the room. NA-F stated she had brushed R26's upper denture prior to placement and further stated she also swabbed R26's mouth with a toothette wetted with water prior to the placement of the upper denture. NA-J confirmed R26 had natural lower teeth present and verified she did not brush the R26's lower teeth with a toothbrush. When interviewed on 7/07/16, at 11:04 a.m. the director of nursing (DON) confirmed R26's lower natural teeth should be brushed with a toothbrush and toothpaste during morning and bedtime cares per the plan of care. The Tuff Memorial Home Care Plan policy, last updated 4/22/16, indicated each care plan would be reviewed every 90 days as required by law.	{2 565}		
{2 920}	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: "Uncorrected based on the following findings. The original licensing order issued on 5/19 /16 will remain in effect. Penalty assessment issued." Based on observation, interview and document	{2 920}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

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{2 920}	Continued From page 5 review the facility failed to ensure oral cares were completed for 2 of 4 residents (R1, R26) reviewed for activities of daily living (ADL). Findings include: R1's quarterly Minimum Data Set (MDS) assessment dated 12/21/15, indicated he required total assistance of two staff for grooming. An oral/dental care area assessment did not trigger for R1 during the prior full MDS assessment. R1's care plan dated 6/14/16, indicated R1 had upper denture which staff leave out due to poor fit and staff were to brush his lower teeth. R1's current Nursing Assistant assignment sheet, indicated R1's teeth should be brushed. R1's Mouth/Throat/Neck/Speech and Communication note dated 6/22/16, indicated R1 had teeth in the lower gum line in very poor condition, many fillings and wore dentures that were loose. A care note from 7/30/15, dental exam identified that R1's teeth had decay, a large amount of plaque at the gumline and should have his teeth brushed 2 times per day. During observation on 7/7/16, at 7:37 a.m. nursing assistants (NA)-F and NA-J performed personal cares for R1. NA-F used a toothette and swabbed once around R1's mouth. When questioned whether R1 had teeth, NA-F replied that he had upper dentures but staff do not place them in the mouth since they don't fit and R1 can eat better without them. NA-F did not brush R1's lower teeth.	{2 920}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{2 920}	Continued From page 6 During interview on 7/7/16, at 12:01 p.m. NA-J stated R1's dentures don't fit anymore because he lost so much weight and consequently staff don't put them in his mouth anymore. She also stated he had bottom teeth but "we don't brush them they just get swabbed, that's what we were told to do." 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 just swabbed with a toothette. R26's significant change in status MDS assessment dated 4/19/16, indicated R26 required extensive assistance of two staff for grooming. The Care Area Assessment (CAA) for oral/dental status did not trigger. 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 and PM 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 transferring him into his	{2 920}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

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{2 920}	Continued From page 7 wheelchair. Once transferred, the NA's assisted R26 with washing his face and combing hair. R26 was then wheeled to the lounge area to watch television prior to breakfast. It was observed that neither NA provided oral hygiene for R26 during morning cares. When interviewed on 7/07/16, at 9:00 a.m. NA-J confirmed she had not provided oral care for R26 during or prior to the observation of AM cares. NA-F confirmed placing R26's upper denture in his mouth prior to the surveyor entering the room. NA-F stated she had brushed R26's upper denture prior to placement and further stated she also swabbed R26's mouth with a toothette wetted with water prior to the placement of the upper denture. NA-J confirmed R26 had natural teeth present and verified she did not brush the R26's bottom teeth with a toothbrush. When interviewed on 7/07/16, at 11:04 a.m. the director of nursing (DON) confirmed R26's lower natural teeth should be brushed with a toothbrush and toothpaste. The DON further confirmed per the toothbrushing audits she had conducted, that lack of oral care continued to be an issue as staff had not consistently provided the appropriate oral hygiene.	{2 920}		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00576 Y1	A. Building 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20302	Correction	ID Prefix 20570	Correction	ID Prefix 20830	Correction
Reg. # MN State Statute 144.6503	Completed	Reg. # 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 4658.0800 Subp. 4 A-I	Completed	Reg. # 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 4658.1415 Subp. 2	Completed	Reg. # MN St. Statute 144.651 Subd. 25	Completed	Reg. # MN St. Statute 626.557 Subd. 3	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 626.557 Subd. 4a	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	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	KS/kfd	7/26/2016	31767	7/7/2016
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? ☐ **YES** ☐ **NO**

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00576 Y1	A. Building 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20302	Correction	ID Prefix 20570	Correction	ID Prefix 20830	Correction
Reg. # MN State Statute 144.6503	Completed	Reg. # 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 4658.0800 Subp. 4 A-I	Completed	Reg. # 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 4658.1415 Subp. 2	Completed	Reg. # MN St. Statute 144.651 Subd. 25	Completed	Reg. # MN St. Statute 626.557 Subd. 3	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 626.557 Subd. 4a	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	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	KS/kfd	7/26/2016	31767	7/7/2016
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? ☐ **YES** ☐ **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QFKO

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00576

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245548**

2. STATE VENDOR OR MEDICAID NO. (L2) **230743000**

3. NAME AND ADDRESS OF FACILITY
(L3) **TUFF MEMORIAL HOME**
(L4) **505 EAST 4TH STREET**
(L5) **HILLS, MN** (L6) **56138**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **05/19/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Susan Kalis, HFE NE II 06/20/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 07/15/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **03/01/1991** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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:

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Email: Kathryn.serie@state.mn.us
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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. 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,

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

Alex Dysthe, Administrator | 505 E. 4th Street, Hills, MN 56138 | Phone: 507-962-3275 | Fax: 507-962-3277 | tuffmemorialhome.com

TUFF MEMORIAL HOME, INC.

Tuff Village Assisted Living & Tuff Retirement Apartments

RECEIVED
JUN 15 2016
Minnesota Department of Health
Marshall

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

KMS approved 6/20/16

The following measures have been identified to correct this deficiency:

CNA mtg to review all inBO – 6/1/16 licensed staff mtg 6/6/16

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
3. Quarterly statements will be sent out to the resident or his or her legal representative. sent statement on 6-15-16
4. The Administrator and Accountant will monitor compliance with this correction. reviewed q 6 mo. Report to QA committee
5. The Tuff Memorial Home will be in compliance by June 28th, 2016. compliance

F225 483.13(c) (2)-(4) Investigate/Report Allegations/Individuals Nurses trained 5 6/24/16

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. Check unwitnessed events + report. PRP trg. + adm review
2. The Director of Nursing and Administrator will monitor compliance with this correction. report run daily by DON Incident report DON + daily falls/incidents reviewed by DON – related to admin
3. The Tuff Memorial Home will be in compliance by June 28th, 2016

F226 483.13(c) Develop/Implement Abuse/Neglect, Etc. Policies

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. mo. DON – updates on VAA/incident reports new orientation
2. Background checks will be done for all employees and they will be under supervision until the background check states otherwise. – all checks + current background + wkly daily audits performed by DON + reported to QA committee monthly →
3. The Administrator will monitor compliance with this correction.–
4. The Tuff Memorial Home will be in compliance by June 28th, 2016.

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

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. med dir. qtly attend/review

RI was updated to include denture + oral care

Auditing all charts/POC to have proper revision/update

audit wkly + random report to QA monthly until in compliance
1st mtg 6/20/16

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

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. Nsg mtg trained audits 6/2 & 6/6
3. Staff will be trained on the importance of documenting the effectiveness following administration of medication. Chg Ns/DON - observe staff @ random cares
4. The Director of Nursing will monitor compliance with this correction. audit wkly - report to monthly QA mtg results. 6/20/16
5. The Tuff Memorial Home will be in compliance by June 28th, 2016.

new DON → Ns. mtg explained (I) behavioral effects of prn meds →

audit interventions for any behav. med for implem. prior prn behav. charting

R48 chart - audited + checked ⇒ report to QA 6/20/16

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 schedule.
3. The Administrator and Director of Nursing will monitor compliance with this correction.
4. The Tuff Memorial Home will be in compliance by June 28th, 2016. DON - check for mo. schedule + check for implement.

report to mo. QA committee 6/20/16

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, R26, R1 have been provided oral cares
3. The Director of Nursing will monitor compliance with this correction.
4. The Tuff Memorial Home will be in compliance by June 28th, 2016.

followed up c oral care obs.

DON/Chg. Ns random audits wkly of staff - report to QA mo.

F329 483.25(l) Drug Regimen is Free from Unnecessary Drugs

1. Staff will be trained on the importance of documenting behaviors and non-pharmacological interventions attempted prior to the administration of a PRN anti-anxiety medication. Inservice date for CNAs 5-24-16
2. The staff will also be trained on the importance of documenting the effectiveness of an antidepressant medication. Chg. r chart for behavioral documentation new tool → computer system.
3. The Director of Nursing will monitor compliance with this correction.
4. The Tuff Memorial Home will be in compliance by June 28th, 2016.

Sleep study conducted for R48 - date 6/10/16
random audits wkly x4 - report to QA monthly.

F428 483.60(c) Drug Regimen Review, Report Irregular, Act On reviewed R48 c pharmacist 6-3-16

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.

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Marshall

F441 483.65 Infection Control, Prevent Spread, Linens R46 obs. for proper urinary care

1. The staff will be trained on the proper hand hygiene after catheter cares.
2. Staff will wash their hands after any catheter handling.
3. Proper hand washing technique will be retrained to employees.
4. The Director of Nursing will monitor compliance with this correction.

DON/Chg Ns. Conduct obs. of cares, including catheter use + audit wkly x4 = then monthly report to QA 6/20/16

5. The Tuff Memorial Home will be in compliance by June 28th, 2016. adm – check w/c monthly + new Res. report to QA

F465 483.70(h) Safe/Functional/Sanitary/Comfortable Environment

1. The staff will be trained to identify when a wheelchair is needing an upgrade. condition of w/chair
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 28th, 2016.

R1+R28 ordered new arm rests

Check w/chair for proper condition / follow up repair

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.

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 non-pharmacological interventions attempted prior to the administration of a PRN anti-anxiety 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.

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 21st, 2016.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	05/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 159 SS=E	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal	F 159		

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

Acting Administrator 6/21/16

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

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TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

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F 159	Continued From page 2 statement of money balance. On 5/17/16, at 3:20 p.m. R46's personal fund account was verified and reviewed with facility receptionist (R)-B. It showed a balance of $50.00 on 5/1/16. No debits or credits were noted on the account ledger. 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 their 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 representative if there had been activity in the account during the month. R-B stated she was unaware the facility was to provide interest bearing accounts for residents with personal fund balances of $50 or greater and the requirement related to quarterly personal fund statements to all residents/responsible parties. Sixteen residents (R46, R2, R16, R38, R1, R40, R41, R3, R11, R43, R5, R28, R18, R22, R29, R27) had personal fund accounts with the facility. A policy related to personal fund accounts was requested but not provided.	F 159		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	05/19/2016

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TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

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F 225	Continued From page 3 registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate and to immediately report injuries of unknown origin and/or allegations of neglect to the State Agency (SA) and/or to the administrator for 2 of 5	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 4 incidents (R28 & R22) reviewed. Findings include: R28 had diagnoses according to the physician orders dated 4/7/16, which included: dementia, major depression, psychosis, anxiety and Alzheimer's disease. R28's quarterly Minimum Data Set (MDS) assessment, dated 3/22/16, identified R28 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated severe cognitive impairment. The MDS further identified R28 required extensive assistance of one staff with all activities of daily living (ADL's). During review of facility incident reports it was noted on 12/25/15, R28 had a fall with significant injury. The details of the fall documented on the incident report dated 12/25/15, at 10:04 p.m. indicated R28's alarm was heard sounding by staff and when staff entered the room, R28 was found lying on the floor in her room on her right side in front of her recliner. R28's head was 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	F 225		

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F 225	Continued From page 5	F 225		

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 provider.

When interviewed on 5/19/16, at 9:36 a.m. the director of nursing (DON) verified the facility had not reported to the SA nor investigated this incident.

R48 had diagnoses that included: Alzheimer's disease, dementia with behavioral disturbance, fibromyalgia, and osteoarthritis per the signed physician's orders dated 4/12/16.

R48's 14-day Minimum Data Set (MDS) assessment dated 4/3/16, identified R48 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated severe cognitive impairment. The MDS further identified R48 required extensive assistance of one staff with all activities of daily living (ADL's).

During review of R48's incident reports it was noted on 3/17/16, R48 had an unwitnessed fall with significant injury. The details of the fall identified on the incident report dated 3/18/16, at 1:35 a.m. indicated the incident occurred on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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. 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 the care plan was being followed. DON further 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 is suspicious because of 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	05/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 7 (16.) IMMEDIATELY: means as soon as possible from the time of the initial knowledge that the incident occurred, has been received or after discovery of the incident. If staff becomes aware of a situation or incident where police, emergency, medical services or protective services should be involved ASAP, the facility should call 911 first and then report to the MDH immediately. The policy further included under identification: (A.) Staff is to notify Administrator IMMEDIATELY concerning any observations or witnessing of abuse, neglect, involuntary seclusion, maltreatment/mistreatment, unknown injury event or misappropriation of personal property administrator along with any patterns, trends or occurrences without interviewing the resident/alleged victim.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to follow their policy related to the investigation and immediate reporting of allegations of abuse and/or injuries of unknown origin for 2 of 5 resident incidents (R28 & R22) reviewed and failed to follow their policy related to	F 226		

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F 226	Continued From page 8 the intial background screening of new employees for 1 of 5 employee (nursing assistant (NA)-A) documents reviewed and who required a background. Findings include: The facility did not implement their Vulnerable Protection Plan revised 7/1/15, which included 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 is suspicious because of 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. (16.) IMMEDIATELY: means as soon as possible from the time of the initial knowledge that the incident occurred, has been received or after discovery of the incident. If staff becomes aware of a situation or incident where police, emergency, medical services or protective services should be involved ASAP, the facility should call 911 first and then report to the MDH immediately. The policy further included under identification: (A.) Staff is to notify Administrator IMMEDIATELY concerning any observations or witnessing of abuse, neglect, involuntary seclusion, maltreatment/mistreatment, unknown injury event or misappropriation of personal property	F 226		

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F 226	Continued From page 9 administrator along with any patterns, trends or occurrences without interviewing the resident/alleged victim. In addition, under the section entitled Screening, the policy included: (B.) background studies are submitted to the Minnesota Department of Human Services by the Administrator on all employees at the Tuff Memorial home pursuant to Minnesota Statutes, Chapter 144. Staff failed to follow their policy related to the investigation, immediate reporting to the administrator and to the State agency when R28 had an injury of unknown origin. R28 had diagnoses according to the physician orders dated 4/7/16, which included: dementia, major depression, psychosis, anxiety and Alzheimer's disease. R28's quarterly Minimum Data Set (MDS) assessment, dated 3/22/16, identified R28 had a Brief Interview for Mental Status (BIMS) score of 3 which indicated severe cognitive impairment. The MDS further identified R28 required extensive assistance of one staff with all activities of daily living (ADL's). During review of facility incident reports it was noted on 12/25/15, R28 had a fall with significant injury. The details of the fall documented on the incident report, dated 12/25/15, at 10:04 p.m. indicated R28's alarm was heard sounding by staff and when staff entered the room, R28 was found lying on the floor in her room on her right side in front of her recliner. R28's head was located at the edge of the recliner by the end table in R28's room. R28 was observed by staff to	F 226		

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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 provider.

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 the State agency when R48 experienced an injury of unknown origin.

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R48 had diagnoses that included: Alzheimer's disease, dementia with behavioral disturbance, fibromyalgia, and osteoarthritis per the signed physician's orders dated 4/12/16.

R48's 14-day Minimum Data Set (MDS) assessment, dated 4/3/16, identified R48 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated severe cognitive impairment. The MDS further identified R48 required extensive assistance of one staff with all activities of daily living (ADL's).

During review of R48's incident reports it was noted on 3/17/16, R48 had an unwitnessed fall with significant injury. The details of the fall identified on the incident report dated 3/18/16, at 1:35 a.m. indicated the incident occurred on 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 the care plan was being followed. DON further confirmed the fall was unwitnessed and R48 was

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F 226	Continued From page 12 unable to tell staff the circumstances related to the fall. NA-A was hired by the facility on 9/10/15. Her employment file lacked evidence of a background check initiated on hire. Copies of the nursing schedules for the current pay period indicated NA-A was working on the floor providing direct resident care at least one day per week. During interview on 5/19/16, at approximately 10:00 a.m. the administrator in training (AIT) indicated he was the responsible party for initiating background studies at the present time, and verified NA-A did not have a background check on file. The AIT presented a copy of a Minnesota Department of Human Services NETStudy 2.0 that was initiated on 5/19/16. The AIT indicated the background study was missed by a previous employee that had been doing them at the time of NA-A's hire.	F 226		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in	F 280		

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F 280	Continued From page 13 disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the plan of care was updated with regard to the use of dentures and oral cares for 1 of 3 residents (R1) reviewed for activities of daily living. Findings include: R1's quarterly Minimum Data Set (MDS) assessment dated 12/21/15, indicated he required total assistance of two staff for grooming. An oral/dental care area assessment did not trigger for R1 during the prior full MDS assessment. R1's care plan dated 5/18/16, indicated R1 had upper dentures and staff were to brush his lower teeth and upper denture. R1's nursing assistant assignment sheet also dated 5/18/16, indicated R1's teeth should be brushed. R1's Mouth/Throat/Neck/Speech and Communication assessment dated 7/20/15, indicated R1 had teeth in the lower gum line in poor condition and wore upper dentures. The assessment also identified R1 had terminal multiple sclerosis (MS).	F 280		

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F 280	Continued From page 14 During observation on 5/18/16, at 8:32 a.m. nursing assistant (NA) -G performed personal cares for R1. NA-G indicated R1 no longer wore dentures stating, "because he eats better without them." NA-H, also present in the room during cares indicated R1 had not worn the dentures since December 2015 (5 months prior). During interview on 5/17/16, at 1:25 p.m. licensed practical nurse (LPN)-A confirmed R1 did not usually wear his dentures as he had lost so much weight and the dentures were very loose. LPN-A further added this was not a concern for R1 as he had pureed foods served at meals. During interview on 5/18/16, at 10:01 a.m. the director of nursing (DON) indicated that R1's care plan should have been updated to include the fact that he was no longer wore dentures. The Tuff Memorial Home Care Plan policy, last updated 4/22/16, indicated each care plan would be reviewed every 90 days as required by law.	F 280		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure oral cares were provided in accordance with the care plan for 3 of	F 282		

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F 282	Continued From page 15 4 residents (R26, R28, R34) reviewed for activities of daily living. In addition, the facility failed to follow the care plan related to documentation of interventions attempted prior to as needed (PRN) Ativan (anti-anxiety medication) use for 1 of 5 residents (R48) reviewed for unnecessary medications. Findings include: R26's significant change in status MDS assessment dated 4/19/16, indicated R26 required extensive assistance of two staff for grooming. The Care Area Assessment (CAA) for oral/dental status did not trigger. R26's care plan last revised on 4/26/16, 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 and PM cares. The nursing assistant assignment sheet dated 5/18/16, indicated R26 was to have his teeth brushed. Morning cares were observed for R26 on 5/18/16, at 7:44 a.m. At 8:17 a.m., NA-H indicated they had completed morning cares for R26. No oral cares were observed to be provided. When asked whether R26 should have had oral cares completed, NA-H indicated "Oh, shoot," and stated she should have brushed R26's teeth and that his dentures should be in a cup in the bathroom. Observation at this time revealed R26 still had his dentures in his mouth and they had not been soaked as directed. NA-H indicated the dentures had probably been in all night as he	F 282		

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F 282	Continued From page 16 sometimes refused oral care. 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 in accordance with the care plan. 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. Staff did not provide dental care for R28 as stated in the plan of care. R28 had diagnoses according to the physician orders dated 4/7/16, which included: dementia, major depression, psychosis, anxiety and Alzheimer's disease. R28's active care plan dated 3/29/16, identified R28 would be able to participate in oral cares on a daily basis. The care plan identified staff would set up R28's dental care supplies. R28's quarterly Minimum Data Set (MDS) assessment dated 3/22/16, identified R28 required extensive assistance of one staff with all activities of daily living (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	F 282		

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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.

When interviewed on 5/19/16, at 8:32 a.m. registered nurse (RN)-C stated oral cares should be completed during morning and bedtime cares. 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 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

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F 282	Continued From page 18 they dressed R34, 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 refused brushing. When interviewed on 5/19/16, at 8:32 a.m. RN-C stated oral cares should have been completed for R34 for the staff who assisted with morning cares, further indicating R34 should have morning and bedtime oral cares due to her poor dental status. R48 was admitted to the facility 1/21/16, with diagnoses including: Alzheimer's disease and dementia with behavioral disturbance per the 4/12/16 signed physician orders. Review of the 14-day Minimum Data Set (MDS) assessment dated 4/3/16, revealed R48 received a Brief Interview for Mental Status (BIMS) score of "3", indicating severe cognitive impairment. This assessment further identified R48 required extensive assistance with all activities of daily living and exhibited rejection of care and wandering behavior 1 to 3 days during the look back period. Review of the 4/12/16, signed physician orders for R48 revealed an order for Ativan 1 mg (milligram) po (by mouth) every 4 hours PRN for anxiety; Give if agitated or wanting to go home,	F 282		

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F 282	Continued From page 19 looking for husband 3 times within 15 minutes; Start date of order- 3/3/16. Review of R48's care plan last revised 5/2/16, included: PRN Ativan every 4 hours if agitated or wanting to go home, looking for husband 3 times within 15 minutes. Try PRN wine, talking about sewing blankets and talking about gardening before giving. Review of the electronic administration record (eMAR) revealed R48 was administered PRN Ativan 35 times from 3/6/16 - 5/14/16. Further review of the resident's eMAR and electronic record indicated documentation related to R48's behavior exhibited and staff interventions attempted prior to administration of Ativan, and effectiveness following administration were only documented 15 out of 35 times. When interviewed on 5/19/16, at 8:20 a.m. licensed practical nurse (LPN)-A stated R48's PRN Ativan is only given if non-pharmacological interventions are not effective. LPN-A confirmed the interventions prior to use were listed on the eMAR. LPN-A further stated when PRN Ativan is given the medication nurse is to document in the "comments" section a description of R48's behavior and interventions attempted prior to administration. When interviewed on 5/18/16, at 2:21 p.m. registered nurse (RN)-B confirmed the eMAR and care plan included specific interventions to attempt prior to administering R48's PRN Ativan. RN-B reviewed R48's PRN Ativan use with the surveyor and confirmed staff were not consistently documenting R48's behavior and interventions attempted prior to administration.	F 282		

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F 282	Continued From page 20 RN-B further confirmed staff were also not consistently documenting the effectiveness of the PRN Ativan and would expect charting to reflect this. When interviewed on 5/19/16, at 9:45 a.m. the director of nursing (DON) confirmed the expectation when giving R48's PRN Ativan would be to document behaviors and interventions attempted prior to administration, and to also document effectiveness as identified on the plan of care.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure services were coordinated with the hospice agency for 1 of 1 residents (R1) reviewed for hospice. Findings include: R1's quarterly Minimum Data Set (MDS) assessment dated 12/21/15, indicated he required total staff assistance in all activities of daily living and was not able to be understood.	F 309		

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TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

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R1's care plan dated 5/18/16, identified that R1 received hospice services and staff were to work together with hospice staff to communicate resident's needs, concerns and comments. The care plan further identified R1 received home health aide visits weekly.

R1's hospice plan of care dated 5/6/16, indicated he received skilled nursing visits one to two times weekly and as needed, social worker visits one to two times per month, home health aide visits weekly and chaplain visits once per month.

During observation on 5/17/16, at 12:34 p.m. R1 was observed lying in his bed with heel protector boots on, and showed no nonverbal signs of distress. R1 was unable to communicate verbally.

During observation on 5/18/16, at 8:32 a.m. nursing assistant (NA)-G was observed performing cares with R1. R1 was unable to communicate and required total assistance from staff to get out of bed into his wheelchair and complete morning cares. No signs of pain or discomfort were observed with transfers.

During interview on 5/17/16, at 1:23 p.m. NA-I indicated he thought there was an hospice aide coming to spend time with R1 today as it was communicated during report from the charge nurse during report. NA-I was not sure whether there was a routine schedule of visits established for R1.

During interview on 5/17/16, at 1:31 p.m. licensed practical nurse (LPN)-A indicated hospice used to provide a calendar identifying their scheduled visits and used have hospice staff provide bed

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F 309	Continued From page 22 baths for R1 and perform skin care which were beneficial for him; however, but now hospice staff only assist with feeding R1 due to weight loss. LPN-A indicated the hospice agency had made a lot of changes recently and indicated "I guess if they come, they come and if they don't, we go on with our business." During interview on 5/17/16, at 1:33 a.m. registered nurse (RN)-E indicated the hospice agency used to provide their schedule of visits; however, confirmed the agency no longer provides this information. During interview on 5/18/16, at 7:41 a.m. trained medication aide (TMA)-A indicated she was unsure what hospice was providing for R1 and indicated she worked full-time at the facility. TMA-A indicated she did not receive any communication regarding the hospice services, unless it involved medications. During interview on 5/17/16, at 10:24 a.m. hospice RN-F indicated she visited weekly with social services and the charge nurse about her findings. RN-F verified hospice staff only helped with feeding and the custodial care was left to the facility staff. RN-F indicated she had instructed hospice staff to document their visits in the schedule book located at the main nursing station. When interviewed on 5/18/16, at 10:01 a.m. the director of nursing (DON) confirmed hospice used provide a calendar with their scheduled visits, however, no longer does. The DON indicated they usually communicated with the social services designee (SSD) and talked to the RN staff after they came to provide services.	F 309		

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F 309	Continued From page 23 During interview on 5/18/16, at 9:55 a.m. the SSD indicated the hospice nurse visited with her after the visit to report any problems and left her documentation on her desk. The SSD was not sure why they no longer provided a calendar, stating that was helpful communication for facility staff to coordinate cares. The SSD indicated the hospice visits vary and she was unaware of any schedule book that hospice visits are recorded. During interview on 5/18/16, at 10:06 a.m. RN-B indicated that hospice had quit providing calendars and did not write down there visits anymore. RN-B further stated that since hospice staff did not come prior to R1 getting up for the day, partial baths were not beneficial for him. When interviewed on 5/18/2016, at 11:39 a.m. hospice RN-F indicated with regard to the lack of hospice providing a schedule and coordinating cares for R1, "I will just take it, it is my fault there is no schedule. We will go back to the calendars." The Hospice Policy of the Tuff Memorial Home last updated 3/29/16, indicated The Tuff Memorial Home staff remain the primary caregivers and the hospice staff are used in addition to this to support the resident and family with physical and emotional end of life issues.	F 309		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		

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F 312	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure oral cares were completed for 4 of 4 residents (R28, R34, R26, R1) reviewed for activities of daily living (ADL). Findings include: Staff did not provide dental care for R28, who required extensive assistance with all ADL's. R28 had diagnoses according to the physician orders dated 4/7/16, which included: dementia, major depression, psychosis, anxiety and Alzheimer's disease. R28's active care plan dated 3/29/16, identified R28 would be able to participate in oral cares on a daily basis. The care plan identified staff would set up R28's dental care supplies. R28's quarterly Minimum Data Set (MDS) assessment dated 3/22/16, identified R28 required extensive assistance of one staff with all activities of daily living (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	F 312		

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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.

When interviewed on 5/19/16, at 8:32 a.m. registered nurse (RN)-C stated oral cares should be completed during morning and bedtime cares. 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, who required extensive assistance with ADL's. 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 from the bed with the use of a mechanical lift

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F 312	Continued From page 26 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 refused brushing. When interviewed on 5/19/16, at 8:32 a.m. RN-C stated oral cares should have been completed for R34 for the staff who assisted with morning cares, further indicating R34 should have morning and bedtime oral cares due to her poor dental status. R26's significant change in status MDS assessment dated 4/19/16, indicated R26 required extensive assistance of two staff for grooming. The Care Area Assessment (CAA) for oral/dental status did not trigger. R26's physical/oral assessment dated 4/18/16, indicated R26 had loosely fitting upper dentures and nine lower natural teeth. R26's care plan last revised on 4/26/16, 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 and PM cares. The nursing assistant assignment sheet dated	F 312		

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F 312	Continued From page 27 5/18/16, indicated R26 was to have his teeth brushed. Morning cares were observed for R26 on 5/18/16, at 7:44 a.m. At 8:17 a.m., NA-H indicated they had completed morning cares for R26. No oral cares were observed to be provided. When asked whether R26 should have had oral cares completed, NA-H indicated "Oh, shoot," and stated she should have brushed R26's teeth and that his dentures should be in a cup in the bathroom. Observation at this time revealed R26 still had his dentures in his mouth and they had not been soaked as directed. NA-H indicated the dentures had probably been in all night as he sometimes refused oral care. R1's quarterly Minimum Data Set (MDS) assessment dated 12/21/15, indicated he required total assistance of two staff for grooming. An oral/dental care area assessment did not trigger for R1 during the prior full MDS assessment. R1's care plan dated 5/18/16, indicated R1 had upper dentures and staff were to brush his lower teeth and upper denture. R1's nursing assistant assignment sheet also dated 5/18/16, indicated R1's teeth should be brushed. R1's Mouth/Throat/Neck/Speech and Communication assessment dated 7/20/15, indicated R1 had teeth in the lower gum line in poor condition and wore upper dentures. The assessment also identified R1 had terminal multiple sclerosis (MS). During interview on 5/16/16, at 6:44 p.m. family member (FM)-A indicated they had concerns that	F 312		

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F 312	Continued From page 28 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.	F 312		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate	F 329		

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F 329	Continued From page 29 indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to consistently document behaviors and non-pharmacological interventions attempted prior to the administration of a PRN (as needed) anti-anxiety medication (Ativan), failed to document effectiveness of Ativan administration and failed to complete a sleep study assessment to determine effectiveness of an antidepressant medication (Remeron) for 1 of 5 residents (R48) reviewed for unnecessary medications. Findings include: R48 was admitted to the facility 1/21/16, with diagnoses including: Alzheimer's disease and dementia with behavioral disturbance per the	F 329		

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F 329	Continued From page 30 4/12/16 signed physician orders. Review of the 14-day Minimum Data Set (MDS) dated 4/3/16, revealed R48 had a Brief Interview for Mental Status (BIMS) score of "3", indicating severe cognitive impairment. The assessment further indicated R48 required extensive assistance with all activities of daily living and exhibited rejection of care and wandering behavior 1 to 3 days during the look back period. Review of the 4/12/16, signed physician orders for R48 also revealed an order for Ativan 1 mg (milligram) po (by mouth) every 4 hours PRN for anxiety; Give if agitated or wanting to go home, looking for husband 3 times within 15 minutes; Start date of order-3/3/16. Review of R48's care plan last revised 5/2/16, included: PRN Ativan every 4 hours if agitated or wanting to go home, looking for husband 3 times within 15 minutes. Try PRN wine, talking about sewing blankets, talking about gardening before giving [Ativan]. Review of the electronic administration record (eMAR) revealed R48 was administered PRN Ativan 35 times from 3/6/16 - 5/14/16. Further review of R48's eMAR and electronic record indicated documentation related to R48's behavior exhibited and staff interventions attempted prior to administration of PRN Ativan and the effectiveness following administration were only documented 15 out of 35 times during this time period. When interviewed on 5/19/16, at 8:20 a.m. licensed practical nurse (LPN)-A stated R48's PRN Ativan was only given if	F 329		

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F 329	Continued From page 31 non-pharmacological interventions are not effective. LPN-A confirmed the interventions to be implemented prior to use were listed on the eMAR. LPN-A further stated when PRN Ativan is administered the medication nurse is required to document in the "comments" section a description of R48's behavior and the interventions attempted prior to administration. When interviewed on 5/18/16, at 2:21 p.m. registered nurse (RN)-B confirmed the eMAR and care plan included specific interventions to attempt prior to administering R48's PRN Ativan. RN-B reviewed R48's PRN Ativan use with the surveyor and confirmed staff were not consistently documenting R48's behavior and interventions attempted prior to administration. RN-B also confirmed staff were also not consistently documenting the effectiveness of the PRN Ativan and would expect documentation to reflect this. When interviewed on 5/19/16, at 9:25 a.m. the consulting pharmacist confirmed staff should be documenting R48's behavior and interventions attempted prior to administration of PRN Ativan and in addition, the effectiveness of each dose administered. 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,	F 329		

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F 329	Continued From page 32 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 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 disturbance. RN-B confirmed a sleep study assessment related to the effectiveness of R48's Remeron was not conducted and should have been. When interviewed on 5/19/16, at 9:25 a.m. the consulting pharmacist stated within 5-7 days after initiation of Remeron there should be some response related to sleep pattern. The pharmacist further confirmed a sleep study assessment should have been conducted within a	F 329		

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F 329	Continued From page 33 week after the initiation of Remeron. When interviewed on 5/19/16, at 9:45 a.m. the director of nursing (DON) confirmed that a sleep study to determine efficacy had not been conducted after initiation of R48's Remeron.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review the consulting pharmacist failed to identify the lack of consistent documentation of behaviors and non-pharmacological interventions attempted prior to administration of a PRN (as needed) anti-anxiety medication (Ativan), failed to identify the lack of documentation related to the effectiveness following Ativan administration and failed to identify the need for a sleep study to assess effectiveness of an antidepressant	F 428		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 34 medication (Remeron) for 1 of 5 residents (R48) reviewed for unnecessary medications. Findings include: R48 was admitted to the facility 1/21/16, with diagnoses including: Alzheimer's disease and dementia with behavioral disturbance per the 4/12/16 signed physician orders. Review of the 14-day Minimum Data Set (MDS) dated 4/3/16, revealed R48 had a Brief Interview for Mental Status (BIMS) score of "3", indicating severe cognitive impairment. The assessment further indicated R48 required extensive assistance with all activities of daily living and exhibited rejection of care and wandering behavior 1 to 3 days during the look back period. Review of the 4/12/16, signed physician orders for R48 also revealed an order for Ativan 1 mg (milligram) po (by mouth) every 4 hours PRN for anxiety; Give if agitated or wanting to go home, looking for husband 3 times within 15 minutes; Start date of order-3/3/16. Review of R48's care plan last revised 5/2/16, included: PRN Ativan every 4 hours if agitated or wanting to go home, looking for husband 3 times within 15 minutes. Try PRN wine, talking about sewing blankets, talking about gardening before giving [Ativan]. Review of the electronic administration record (eMAR) revealed R48 was administered PRN Ativan 35 times from 3/6/16 - 5/14/16. Further review of R48's eMAR and electronic record indicated documentation related to R48's behavior exhibited and staff interventions	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	05/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 35 attempted prior to administration of PRN Ativan and the effectiveness following administration were only documented 15 out of 35 times during this time period. When interviewed on 5/19/16, at 8:20 a.m. licensed practical nurse (LPN)-A stated R48's PRN Ativan was only given if non-pharmacological interventions are not effective. LPN-A confirmed the interventions to be implemented prior to use were listed on the eMAR. LPN-A further stated when PRN Ativan is administered the medication nurse is required to document in the "comments" section a description of R48's behavior and the interventions attempted prior to administration. When interviewed on 5/18/16, at 2:21 p.m. registered nurse (RN)-B confirmed the eMAR and care plan included specific interventions to attempt prior to administering R48's PRN Ativan. RN-B reviewed R48's PRN Ativan use with the surveyor and confirmed staff were not consistently documenting R48's behavior and interventions attempted prior to administration. RN-B also confirmed staff were also not consistently documenting the effectiveness of the PRN Ativan and would expect documentation to reflect this. When interviewed on 5/19/16, at 9:25 a.m. the consulting pharmacist confirmed staff should be documenting R48's behavior and interventions attempted prior to administration of PRN Ativan and in addition, the effectiveness of each dose administered. When interviewed on 5/19/16, at 9:45 a.m. the director of nursing (DON) confirmed the	F 428		

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F 428	Continued From page 36 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 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 disturbance. RN-B confirmed a sleep study assessment related to the effectiveness of R48's Remeron was not conducted and should have	F 428		

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F 428	Continued From page 37 been. When interviewed on 5/19/16, at 9:45 a.m. the director of nursing (DON) confirmed that a sleep study to determine efficacy had not been conducted after initiation of R48's Remeron. When interviewed on 5/19/16, at 9:25 a.m. the consulting pharmacist stated within 5-7 days after initiation of Remeron there should be some response related to sleep pattern. The pharmacist further confirmed a sleep study assessment to determine effectiveness should have been conducted within a week after the initiation of Remeron. Documentation noted on the monthly drug regimen reviews dated 3/15/16, 4/5/16 and 5/3/16 by the consulting pharmacist lacked any mention related to: inadequate staff monitoring of R48's response to PRN Ativan, inconsistent documentation related to interventions attempted prior to PRN Ativan administration and the lack of monitoring for the effectiveness of Remeron after initiation.	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	F 441		

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F 441	Continued From page 38 (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure proper hand hygiene after catheter cares was performed for 1 of 4 residents (R26) observed during activities of daily living. Findings include: R26's significant change in status Minimum Data	F 441		

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F 441	Continued From page 39 Set (MDS) assessment dated 4/19/16, indicated R26 required extensive assistance of two staff for grooming and activities of daily living (ADL). R26's care plan last revised on 4/26/16, indicated that R26 had Lewy Body dementia, required extensive assistance with grooming and had a urinary catheter. On 5/18/16, at 7:44 a.m. nursing assistant (NA)-G and NA-H were observed performing morning cares for R26. NA-H applied clean gloves and then proceeded to drain urine from R26's urinary catheter into a graduate container. NA-H dumped the contents containing approximately 500 milliliters of urine into the toilet, rinsed the container and put it on the back of R26's toilet. NA-G, who was assisting with R26's cares, requested NA-H grab another set of gloves from the bathroom. Still wearing the soiled gloves used to empty the urine, NA-H grabbed a set of gloves from the full box mounted on the wall and handed the clean gloves to NA-G. NA-H proceeded to apply R26's socks and shoes before removing her soiled gloves. After completion of R26's cares, NA-H was interviewed as to whether she changed her gloves and washed her hands after emptying R1's catheter and before reaching into the glove box to remove additional clean gloves and applying R26's clothing. NA-H indicated she could not recall, but should have done so. During interview on 5/18/16, at 10:01 a.m. the director of nursing (DON) indicated staff needed to be changing gloves and washing their hands after catheter cares, "They get in-servicing on that."	F 441		

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F 441	Continued From page 40 The Hand Hygiene Policy of the Tuff Memorial Home, dated 3/29/16 indicated hand washing must be done any time your hands are visibly soiled, before and after eating, after personal use of the bathroom, after handling dirty linen, soiled utensils or any used dressings, and with any resident who has an infection not killed by hand sanitizer e.g. C. Diff.	F 441		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure wheelchairs were kept in working repair for 2 of 2 residents (R1 & R28) observed with torn wheelchair coverings. Findings include: R1's quarterly Minimum Data Set (MDS) assessment dated 12/21/15, indicated he required total assistance of two staff for transfers, total assistance for locomotion in the wheelchair and was generally unable to be understood. During observation on 5/18/16, at 1:42 p.m. R1's wheelchair was noted with a 6" ripped area on the left headrest, with exposed foam sticking out of the tear. Maintenance (M)-A observed the area and confirmed it should have been reported to	F 465		

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F 465	Continued From page 41 maintenance by nursing, probably by the overnight shift who cleaned the wheelchairs and saw them on a daily basis. M-A indicated he procedure for reporting was to write it down on a notebook at the nursing station and verified nothing was on his notebook regarding R1's wheelchair. M-A further indicated he did not believe there was a formal policy regarding this. R28's quarterly Minimum Data Set (MDS) dated 3/22/16, included a Brief Interview for Mental Status (BIMS) score of 3, indicating severely impaired cognition. The MDS further indicated the resident required extensive assistance with all activities of daily living. On 5/16/16, at 4:17 p.m. R28 was observed sitting in her wheelchair (w/c) in her room. The armrests on the w/c were observed with tears with jagged edges along the outer edge of each armrest exposing the foam padding underneath. The right armrest also had a round circular area on the top of the armrest where the vinyl was missing exposing the foam padding underneath. When interviewed on 5/18/16, at 9:46 a.m. the maintenance supervisor (MS) stated when maintenance issues are identified, staff are to write them down on a clipboard located at the nurses station. MS further stated he checks the list several times throughout the day when working. MS stated being unaware of any issues with R28's w/c as he had not been informed verbally by staff nor had it been identified on his maintenance list. MS and surveyor observed the list located on a clipboard at the nurses station and confirmed R28's torn w/c armrests had not been added to the list. MS and surveyor proceeded to R28's room. Upon observation, MS acknowledged that R28's w/c armrests need	F 465		

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F 465	Continued From page 42 replacing and confirmed the jagged edges could cause skin tearing as well as not being a cleanable surface. MS stated he depended upon the staff to let him know about w/c issues as he does not audit the w/c's for maintenance concerns. MS further stated the night staff are responsible for cleaning of the w/c's and should have identified and brought R28's torn w/c armrests to his attention.	F 465		

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	245548	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/17/2016

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Tuff Memorial Home was found to be not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or By email to:	K 000	APPROVED By Tom Linhoff at 2:33 pm, Jun 17, 2016 RECEIVED JUN 17 2016 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Acting Administrator	6/13/16

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Tuff Memorial Home was constructed as follows: The original building was constructed in 1959, is one-story, has a partial basement, is fully fire sprinkler protected and is of Type II(111) construction; The 1st Addition was constructed in 1962, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 2nd Addition was constructed in 1975, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 3rd Addition was constructed in 1988, is one-story, has a full basement, is fully fire sprinkler protected and is of Type V(111) construction; The 4th Addition was constructed in 1998, is one-story, has no basement, is fully fire sprinkler protected and is of Type V(000) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. There are two-hour fire walls equipped with labeled 90-minute fire door	K 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 2 assemblies, separating the buildings of Type II(111) construction from the additions of Type V(000) construction. The facility has a capacity of 50 beds and had a census of 45 at time of the survey. Because the original building and the four additions met the construction types allowed for existing buildings, the facility was surveyed as one building, and one (1) Form CMS-2786R booklet was completed. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This Standard is not met as evidenced by: Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 FINDINGS INCLUDE: During Facility Inspection on May 17, 2016, between the hours of 10:30 AM and 1:00 PM, observation revealed that the smoke barrier # 4	K 025		

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

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K 025	Continued From page 3 has a penetration around some cables above the lay-in ceiling. This was also observed by the Facility Maintenance Director.	K 025		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This Standard is not met as evidenced by: Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 FINDINGS INCLUDE: During the Facility Inspection on May 17, 2016, between the hours of 10:30 AM and 1:00 PM, an extension cord was observed in Resident Room #40 being used as a source of fixed wiring. This deficient practice was observed by the Facility Maintenance Director. NOTE: All Resident Rooms should be used to ensure extension cords are not being used.	K 147		

Alex Dysthe, Administrator

505 E. 4th Street
Hills, MN 56138

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

tuffmemorialhome.com

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
2. The Tuff Memorial Home will be in compliance by May 23rd, 2016
3. The Administrator and Maintenance Supervisor are responsible for monitoring compliance with this correction.

Minnesota Department of Health

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to:

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Email: Kathryn.serie@state.mn.us
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,

Kamala Fiske-Downing

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

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00576	A. BUILDING: _____ B. WING _____	05/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: 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	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000	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 which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct	2 302		

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2 302	Continued From page 2 care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide to consumers in written or electronic format a description of the Alzheimer's training program, categories of employees trained, frequency of training and basic topics covered. Findings include: During interview on 5/17/16, at 3:1 p.m. the social work designee (SSD) indicated there was no documentation available indicating the facility provided any information related to Alzheimer's training in electronic or written materials for the public. The SSD stated, " I guess I was not aware of that [need to ensure provided in written or electronic format]. "	2 302		

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2 302	Continued From page 3 SUGGESTED METHOD OF CORRECTION: The facility could revise their written and electronic materials to include necessary information regarding their training program and categories of staff trained, and create policies and procedures to ensure consumers are informed of this information. The QA committee could audit for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure oral cares were provided in accordance with the care plan for 3 of 4 residents (R26, R28, R34) reviewed for activities of daily living. In addition, the facility failed to follow the care plan related to documentation of interventions attempted prior to as needed (PRN) Ativan (anti-anxiety medication) use for 1 of 5 residents (R48) reviewed for unnecessary medications. Findings include: R26's significant change in status MDS	2 565		

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2 565	Continued From page 4	2 565		

assessment dated 4/19/16, indicated R26 required extensive assistance of two staff for grooming. The Care Area Assessment (CAA) for oral/dental status did not trigger.

R26's care plan last revised on 4/26/16, 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 and PM cares.

The nursing assistant assignment sheet dated 5/18/16, indicated R26 was to have his teeth brushed.

Morning cares were observed for R26 on 5/18/16, at 7:44 a.m. At 8:17 a.m., NA-H indicated they had completed morning cares for R26. No oral cares were observed to be provided. When asked whether R26 should have had oral cares completed, NA-H indicated "Oh, shoot," and stated she should have brushed R26's teeth and that his dentures should be in a cup in the bathroom. Observation at this time revealed R26 still had his dentures in his mouth and they had not been soaked as directed. NA-H indicated the dentures had probably been in all night as he sometimes refused oral care.

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 in accordance with the care plan.

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

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2 565	Continued From page 5 as much as possible. Soak dentures at HS in personal denture cup. Staff did not provide dental care for R28 as stated in the plan of care. R28 had diagnoses according to the physician orders dated 4/7/16, which included: dementia, major depression, psychosis, anxiety and Alzheimer's disease. R28's active care plan dated 3/29/16, identified R28 would be able to participate in oral cares on a daily basis. The care plan identified staff would set up R28's dental care supplies. R28's quarterly Minimum Data Set (MDS) assessment dated 3/22/16, identified R28 required extensive assistance of one staff with all activities of daily living (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. When interviewed on 5/19/16, at 8:32 a.m. registered nurse (RN)-C stated oral cares should be completed during morning and bedtime cares.	2 565		

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2 565	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 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 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 refused brushing. When interviewed on 5/19/16, at 8:32 a.m. RN-C	2 565		

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2 565	Continued From page 7	2 565		

stated oral cares should have been completed for R34 for the staff who assisted with morning cares, further indicating R34 should have morning and bedtime oral cares due to her poor dental status.

R48 was initially admitted to the facility 1/21/16 with diagnoses including: Alzheimer's disease and dementia with behavioral disturbance per the 4/12/16 signed physician orders.

Review of the 14-day Minimum Data Set (MDS) assessment dated 4/3/16, revealed a Brief Interview for Mental Status (BIMS) score of "3" indicating severe cognitive impairment. The assessment further identified R48 required extensive assistance with all activities of daily living and exhibited rejection of care and wandering behavior 1 to 3 days during the look back period.

Review of the 4/12/16, signed physician orders revealed an order for Ativan 1 mg po (by mouth) every 4 hours PRN for anxiety. Give if agitated or wanting to go home, looking for husband 3 times within 15 minutes; Start date of order 3/3/16.

Review of the care plan last revised 5/2/16, included: PRN Ativan every 4 hours if agitated or wanting to go home, looking for husband 3 times within 15 minutes. Try PRN wine, talking about sewing blankets and talking about gardening before giving.

Review of the electronic administration record (eMAR) revealed R48 was administered PRN Ativan 35 times from 3/6/16 - 5/14/16. Further review of the resident's eMAR and electronic record indicated documentation related to R48's behavior exhibited and staff interventions

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2 565	Continued From page 8 attempted prior to administration of Ativan, and effectiveness following administration were only documented 15 out of 35 times. When interviewed on 5/19/16, at 8:20 a.m. licensed practical nurse (LPN)-A stated R48's PRN Ativan is only given if non-pharmacological interventions are not effective. LPN-A confirmed the interventions prior to use were listed on the eMAR. LPN-A further stated when PRN Ativan is given the medication nurse is to document in the "comments" section a description of R48's behavior and interventions attempted prior to administration. When interviewed on 5/18/16, at 2:21 p.m. registered nurse (RN)-B confirmed the eMAR and care plan included specific interventions to attempt prior to administering R48's PRN Ativan. RN-B reviewed R48's PRN Ativan use with the surveyor and confirmed staff were not consistently documenting R48's behavior and interventions attempted prior to administration. RN-B further confirmed staff were also not consistently documenting the effectiveness of the PRN Ativan and would expect charting to reflect this. When interviewed on 5/19/16, at 9:45 a.m. the director of nursing (DON) confirmed the expectation when giving R48's PRN Ativan would be to document behaviors and interventions attempted prior to administration, and to also document effectiveness as identified on the plan of care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could re-educate staff on following resident care plans. The DON or designee could develop and	2 565		

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2 565	Continued From page 9 implement an auditing system as part of their quality assurance program to maintain compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the plan of care was updated with regard to the use of dentures and oral cares for 1 of 3 residents (R1) reviewed for activities of daily living. Findings include: R1's quarterly Minimum Data Set (MDS) assessment dated 12/21/15, indicated he required total assistance of two staff for grooming. An oral/dental care area assessment did not trigger for R1 during the prior full MDS	2 570		

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2 570	Continued From page 10 assessment. R1's care plan dated 5/18/16, indicated R1 had upper dentures and staff were to brush his lower teeth and upper denture. R1's nursing assistant assignment sheet also dated 5/18/16, indicated R1's teeth should be brushed. R1's Mouth/Throat/Neck/Speech and Communication assessment dated 7/20/15, indicated R1 had teeth in the lower gum line in poor condition and wore upper dentures. The assessment also indentified R1 had terminal multiple sclerosis (MS). During observation on 5/18/16, at 8:32 a.m. nursing assistant (NA) -G performed personal cares for R1. NA-G indicated R1 no longer wore dentures stating, "because he eats better without them." NA-H, also present in the room during cares indicated R1 had not worn the dentures since December 2015 (5 months prior). During interview on 5/17/16, at 1:25 p.m. licensed practical nurse (LPN)-A confirmed R1 did not usually wear his dentures as he had lost so much weight and the dentures were very loose. LPN-A further added this was not a concern for R1 as he had pureed foods served at meals. During interview on 5/18/16, at 10:01 a.m. the director of nursing (DON) indicated that R1's care plan should have been updated to include the fact that he was no longer wore dentures. The Tuff Memorial Home Care Plan policy, last upedated 4/22/16 indicated each care plan would be reviewed every 90 days as required by law. SUGGESTED METHOD OF CORRECTION: The	2 570		

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2 570	Continued From page 11 director of nursing (DON) or designee, could provide training for all nursing staff and review current policy related to the timeliness of care plan revisions. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure services were coordinated with the hospice agency for 1 of 1 residents (R1) reviewed for hospice. Findings include: R1's quarterly Minimum Data Set (MDS) assessment dated 12/21/15, indicated he	2 830		

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	00576	A. BUILDING: _____ B. WING _____	05/19/2016

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2 830	Continued From page 12 required total staff assistance in all activities of daily living and was not able to be understood. R1's care plan dated 5/18/16, identified that R1 received hospice services and staff were to work together with hospice staff to communicate resident's needs, concerns and comments. The care plan further identified R1 received home health aide visits weekly. R1's hospice plan of care dated 5/6/16, indicated he received skilled nursing visits one to two times weekly and as needed, social worker visits one to two times per month, home health aide visits weekly and chaplain visits once per month. During observation on 5/17/16, at 12:34 p.m. R1 was observed lying in his bed with heel protector boots on, and showed no nonverbal signs of distress. R1 was unable to communicate verbally. During observation on 5/18/16, at 8:32 a.m. nursing assistant (NA)-G was observed performing cares with R1. R1 was unable to communicate and required total assistance from staff to get out of bed into his wheelchair and complete morning cares. No signs of pain or discomfort were observed with transfers. During interview on 5/17/16, at 1:23 p.m. NA-I indicated he thought there was an hospice aide coming to spend time with R1 today as it was communicated during report from the charge nurse during report. NA-I was not sure whether there was a routine schedule of visits established for R1. During interview on 5/17/16, at 1:31 p.m. licensed practical nurse (LPN)-A indicated hospice used to	2 830		

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2 830	Continued From page 13 provide a calendar identifying their scheduled visits and used have hospice staff provide bed baths for R1 and perform skin care which were beneficial for him; however, but now hospice staff only assist with feeding R1 due to weight loss. LPN-A indicated the hospice agency had made a lot of changes recently and indicated "I guess if they come, they come and if they don't, we go on with our business." During interview on 5/17/16, at 1:33 a.m. registered nurse (RN)-E indicated the hospice agency used to provide their schedule of visits; however, confirmed the agency no longer provides this information. During interview on 5/18/16, at 7:41 a.m. trained medication aide (TMA)-A indicated she was unsure what hospice was providing for R1 and indicated she worked full-time at the facility. TMA-A indicated she did not receive any communication regarding the hospice services, unless it involved medications. During interview on 5/17/16, at 10:24 a.m. hospice RN-F indicated she visited weekly with social services and the charge nurse about her findings. RN-F verified hospice staff only helped with feeding and the custodial care was left to the facility staff. RN-F indicated she had instructed hospice staff to document their visits in the schedule book located at the main nursing station. When interviewed on 5/18/16, at 10:01 a.m. the director of nursing (DON) confirmed hospice used provide a calendar with their scheduled visits, however, no longer does. The DON indicated they usually communicated with the social services designee (SSD) and talked to the RN	2 830		

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2 830	Continued From page 14 staff after they came to provide services. During interview on 5/18/16, at 9:55 a.m. the SSD indicated the hospice nurse visited with her after the visit to report any problems and left her documentation on her desk. The SSD was not sure why they no longer provided a calendar, stating that was helpful communication for facility staff to coordinate cares. The SSD indicated the hospice visits vary and she was unaware of any schedule book that hospice visits are recorded. During interview on 5/18/16, at 10:06 a.m. RN-B indicated that hospice had quit providing calendars and did not write down there visits anymore. RN-B further stated that since hospice staff did not come prior to R1 getting up for the day, partial baths were not beneficial for him. When interviewed on 5/18/2016, at 11:39 a.m. hospice RN-F indicated with regard to the lack of hospice providing a schedule and coordinating cares for R1, "I will just take it, it is my fault there is no schedule. We will go back to the calendars." The Hospice Policy of the Tuff Memorial Home last updated 3/29/16, indicated The Tuff Memorial Home staff remain the primary caregivers and the hospice staff are used in addition to this to support the resident and family with physical and emotional end of life issues. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could meet with all contracted hospice providers and facility staff to review current policy related to hospice services and coordination of care. The DON or designee could perform random audits to ensure compliance and review findings at quality assessment and assurance committee meetings.	2 830		

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2 830	Continued From page 15 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure oral cares were completed for 4 of 4 residents (R28, R34, R26, R1) reviewed for activities of daily living (ADL). Findings include: Staff did not provide dental care for R28, who required extensive assistance with all ADL's. R28 had diagnoses according to the physician orders dated 4/7/16, which included: dementia, major depression, psychosis, anxiety and Alzheimer's disease. R28's active care plan dated 3/29/16, identified R28 would be able to participate in oral cares on a daily basis. The care plan identified staff would set up R28's dental care supplies. R28's quarterly Minimum Data Set (MDS) assessment dated 3/22/16, identified R28 required extensive assistance of one staff with all	2 920		

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2 920	Continued From page 16 activities of daily living (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. When interviewed on 5/19/16, at 8:32 a.m. registered nurse (RN)-C stated oral cares should be completed during morning and bedtime cares. 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, who required extensive assistance with ADL's. 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	2 920		

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2 920	Continued From page 17 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. They dressed R34 and placed an incontinent brief. NA-E and NA-F then 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 refused brushing. When interviewed on 5/19/16, at 8:32 a.m. RN-C stated oral cares should have been completed for R34 for the staff who assisted with morning cares, further indicating R34 should have morning and evening oral care due to the poor dental status. R26's significant change in status MDS assessment dated 4/19/16, indicated R26 required extensive assistance of two staff for grooming. The Care Area Assessment (CAA) for oral/dental status did not trigger. R26's physical/oral assessment dated 4/18/16, indicated R26 had loosely fitting upper dentures and nine lower natural teeth.	2 920		

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2 920	Continued From page 18 R26's care plan last revised on 4/26/16, 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 and PM cares. The nursing assistant assignment sheet dated 5/18/16, indicated R26 was to have his teeth brushed. Morning cares were observed for R26 on 5/18/16, at 7:44 a.m. At 8:17 a.m., NA-H indicated they had completed morning cares for R26. No oral cares were observed to be provided. When asked whether R26 should have had oral cares completed, NA-H indicated "Oh, shoot," and stated she should have brushed R26's teeth and that his dentures should be in a cup in the bathroom. Observation at this time revealed R26 still had his dentures in his mouth and they had not been soaked as directed. NA-H indicated the dentures had probably been in all night as he sometimes refused oral care. R1's quarterly Minimum Data Set (MDS) assessment dated 12/21/15, indicated he required total assistance of two staff for grooming. An oral/dental care area assessment did not trigger for R1 during the prior full MDS assessment. R1's care plan dated 5/18/16, indicated R1 had upper dentures and staff were to brush his lower teeth and upper denture. R1's nursing assistant assignment sheet also dated 5/18/16, indicated R1's teeth should be brushed. R1's Mouth/Throat/Neck/Speech and	2 920		

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2 920	Continued From page 19 Communication assessment dated 7/20/15, indicated R1 had teeth in the lower gum line in poor condition and wore upper dentures. The assessment also identified R1 had terminal multiple sclerosis (MS). During interview on 5/16/16, at 6:44 p.m. family member (FM)-A indicated they had concerns that 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. SUGGESTED METHOD OF CORRECTION:	2 920		

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2 920	Continued From page 20 The director of nursing (DON) or designee, could provide education on the performance of providing morning oral care consistently to residents per the plan of care. An audit could be conducted to ensure oral care is provided by staff. The results could be reported to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and	21390		

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21390	Continued From page 21 I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure proper hand hygiene after catheter cares was performed for 1 of 4 residents (R26) observed during activities of daily living. Findings include: R26's significant change in status Minimum Data Set (MDS) assessment dated 4/19/16, indicated R26 required extensive assistance of two staff for grooming and activities of daily living (ADL). R26's care plan last revised on 4/26/16, indicated that R26 had Lewy Body dementia, required extensive assistance with grooming and had a urinary catheter. On 5/18/16, at 7:44 a.m. nursing assistant (NA)-G and NA-H were observed performing morning cares for R26. NA-H applied clean gloves and then proceeded to drain urine from R26's urinary catheter into a graduate container. NA-H dumped the contents of the container containing approximately 500 milliliters of urine into the toilet, rinsed the container and put it on the back of R26's toilet. NA-G, who was assisting with R26's cares, requested NA-H grab another set of gloves from the bathroom. Still wearing the soiled gloves used to empty the urine, NA-H grabbed a set of gloves from the full box mounted on the wall and handed the clean gloves to NA-G. NA-H proceeded to apply R26's socks and shoes before removing her soiled gloves. After	21390		

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21390	Continued From page 22 completion of R26's cares, NA-H was interviewed as to whether she changed her gloves and washed her hands after emptying R1's catheter and before reaching into the glove box to remove additional clean gloves and applying R26's clothing. NA-H indicated she could not recall, but should have done so. During interview on 5/18/16, at 10:01 a.m. the director of nursing (DON) indicated staff needed to be changing gloves and washing their hands after catheter cares, "They get in-servicing on that." The Hand Hygiene Policy of the Tuff Memorial Home, dated 3/29/16 indicated hand washing must be done any time your hands are visibly soiled, before and after eating, after personal use of the bathroom, after handling dirty linen, soiled utensils or any used dressings, and with any resident who has an infection not killed by hand sanitizer e.g. C. Diff. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review policies and procedures to ensure proper infection control techniques are followed. Facility staff could be re-educated and an auditing system developed to ensure compliance. The results of the audit could be reviewed at the quarterly quality assurance committee meetings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist	21530		

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21530	Continued From page 23	21530		

currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change.

B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician.

C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee.

This MN Requirement is not met as evidenced by:

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21530	Continued From page 24 Based on interview and document review the consulting pharmacist failed to identify the lack of consistent documentation of behaviors and non-pharmacological interventions attempted prior to administration of a PRN (as needed) anti-anxiety medication (Ativan), failed to identify the lack of documentation related to the effectiveness following Ativan administration and failed to identify the need for a sleep study to assess effectiveness of an antidepressant medication (Remeron) for 1 of 5 residents (R48) reviewed for unnecessary medications. Findings include: R48 was admitted to the facility 1/21/16, with diagnoses including: Alzheimer's disease and dementia with behavioral disturbance per the 4/12/16 signed physician orders. Review of the 14-day Minimum Data Set (MDS) dated 4/3/16, revealed R48 had a Brief Interview for Mental Status (BIMS) score of "3", indicating severe cognitive impairment. The assessment further indicated R48 required extensive assistance with all activities of daily living and exhibited rejection of care and wandering behavior 1 to 3 days during the look back period. Review of the 4/12/16, signed physician orders for R48 also revealed an order for Ativan 1 mg (milligram) po (by mouth) every 4 hours PRN for anxiety; Give if agitated or wanting to go home, looking for husband 3 times within 15 minutes; Start date of order-3/3/16. Review of R48's care plan last revised 5/2/16, included: PRN Ativan every 4 hours if agitated or wanting to go home, looking for husband 3 times within 15 minutes. Try PRN wine, talking about	21530		

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21530	Continued From page 25 sewing blankets, talking about gardening before giving [Ativan]. Review of the electronic administration record (eMAR) revealed R48 was administered PRN Ativan 35 times from 3/6/16 - 5/14/16. Further review of R48's eMAR and electronic record indicated documentation related to R48's behavior exhibited and staff interventions attempted prior to administration of PRN Ativan and the effectiveness following administration were only documented 15 out of 35 times during this time period. When interviewed on 5/19/16, at 8:20 a.m. licensed practical nurse (LPN)-A stated R48's PRN Ativan was only given if non-pharmacological interventions are not effective. LPN-A confirmed the interventions to be implemented prior to use were listed on the eMAR. LPN-A further stated when PRN Ativan is administered the medication nurse is required to document in the "comments" section a description of R48's behavior and the interventions attempted prior to administration. When interviewed on 5/18/16, at 2:21 p.m. registered nurse (RN)-B confirmed the eMAR and care plan included specific interventions to attempt prior to administering R48's PRN Ativan. RN-B reviewed R48's PRN Ativan use with the surveyor and confirmed staff were not consistently documenting R48's behavior and interventions attempted prior to administration. RN-B also confirmed staff were also not consistently documenting the effectiveness of the PRN Ativan and would expect documentation to reflect this. When interviewed on 5/19/16, at 9:25 a.m. the	21530		

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21530	Continued From page 26 consulting pharmacist confirmed staff should be documenting R48's behavior and interventions attempted prior to administration of PRN Ativan and in addition, the effectiveness of each dose administered. 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 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	21530		

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21530	Continued From page 27 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. When interviewed on 5/19/16, at 9:45 a.m. the director of nursing (DON) confirmed that a sleep study to determine efficacy had not been conducted after initiation of R48's Remeron. When interviewed on 5/19/16, at 9:25 a.m. the consulting pharmacist stated within 5-7 days after initiation of Remeron there should be some response related to sleep pattern. The pharmacist further confirmed a sleep study assessment to determine effectiveness should have been conducted within a week after the initiation of Remeron. Documentation noted on the monthly drug regimen reviews dated 3/15/16, 4/5/16 and 5/3/16 by the consulting pharmacist lacked any mention related to: inadequate staff monitoring of R48's response to PRN Ativan, inconsistent documentation related to interventions attempted prior to PRN Ativan administration and the lack of monitoring for the effectiveness of Remeron after initiation. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. The DON or designee, could audit behavior and non-pharmacological	21530		

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21530	Continued From page 28 intervention documentation and report back to the quality assessment and assurance committee. An audit tool could be developed to monitor the effectiveness of PRN medications. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to consistently document behaviors and non-pharmacological interventions attempted	21540		

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21540	Continued From page 29	21540		

prior to the administration of a PRN (as needed) anti-anxiety medication (Ativan), failed to document effectiveness of Ativan administration and failed to complete a sleep study assessment to determine effectiveness of an antidepressant medication (Remeron) for 1 of 5 residents (R48) reviewed for unnecessary medications.

Findings include:

R48 was admitted to the facility 1/21/16, with diagnoses including: Alzheimer's disease and dementia with behavioral disturbance per the 4/12/16 signed physician orders.

Review of the 14-day Minimum Data Set (MDS) dated 4/3/16, revealed R48 had a Brief Interview for Mental Status (BIMS) score of "3", indicating severe cognitive impairment. The assessment further indicated R48 required extensive assistance with all activities of daily living and exhibited rejection of care and wandering behavior 1 to 3 days during the look back period.

Review of the 4/12/16, signed physician orders for R48 also revealed an order for Ativan 1 mg (milligram) po (by mouth) every 4 hours PRN for anxiety; Give if agitated or wanting to go home, looking for husband 3 times within 15 minutes; Start date of order-3/3/16.

Review of R48's care plan last revised 5/2/16, included: PRN Ativan every 4 hours if agitated or wanting to go home, looking for husband 3 times within 15 minutes. Try PRN wine, talking about sewing blankets, talking about gardening before giving [Ativan].

Review of the electronic administration record (eMAR) revealed R48 was administered PRN

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21540	Continued From page 30 Ativan 35 times from 3/6/16 - 5/14/16. Further review of R48's eMAR and electronic record indicated documentation related to R48's behavior exhibited and staff interventions attempted prior to administration of PRN Ativan and the effectiveness following administration were only documented 15 out of 35 times during this time period. When interviewed on 5/19/16, at 8:20 a.m. licensed practical nurse (LPN)-A stated R48's PRN Ativan was only given if non-pharmacological interventions are not effective. LPN-A confirmed the interventions to be implemented prior to use were listed on the eMAR. LPN-A further stated when PRN Ativan is administered the medication nurse is required to document in the "comments" section a description of R48's behavior and the interventions attempted prior to administration. When interviewed on 5/18/16, at 2:21 p.m. registered nurse (RN)-B confirmed the eMAR and care plan included specific interventions to attempt prior to administering R48's PRN Ativan. RN-B reviewed R48's PRN Ativan use with the surveyor and confirmed staff were not consistently documenting R48's behavior and interventions attempted prior to administration. RN-B also confirmed staff were also not consistently documenting the effectiveness of the PRN Ativan and would expect documentation to reflect this. When interviewed on 5/19/16, at 9:25 a.m. the consulting pharmacist confirmed staff should be documenting R48's behavior and interventions attempted prior to administration of PRN Ativan and in addition, the effectiveness of each dose administered.	21540		

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21540	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 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 disturbance. RN-B confirmed a sleep study	21540		

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21540	Continued From page 32 assessment related to the effectiveness of R48's Remeron was not conducted and should have been. When interviewed on 5/19/16, at 9:25 a.m. the consulting pharmacist stated within 5-7 days after initiation of Remeron there should be some response related to sleep pattern. The pharmacist further confirmed a sleep study assessment should have been conducted within a week after the initiation of Remeron. When interviewed on 5/19/16, at 9:45 a.m. the director of nursing (DON) confirmed that a sleep study to determine efficacy had not been conducted after initiation of R48's Remeron. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of mediation usage. The DON or designee, along with the pharmacist, could audit medication review on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program.	21685		

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21685	Continued From page 33 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure wheelchairs were kept in working repair for 2 of 2 residents (R1 & R28) observed with torn wheelchair coverings. Findings include: R1's quarterly Minimum Data Set (MDS) assessment dated 12/21/15, indicated he required total assistance of two staff for transfers, total assistance for locomotion in the wheelchair and was generally unable to be understood. During observation on 5/18/16, at 1:42 p.m. R1's wheelchair was noted with a 6" ripped area on the left headrest, with exposed foam sticking out of the tear. Maintenance (M)-A observed the area and confirmed it should have been reported to maintenance by nursing, probably by the overnight shift who cleaned the wheelchairs and saw them on a daily basis. M-A indicated he procedure for reporting was to write it down on a notebook at the nursing station and verified nothing was on his notebook regarding R1's wheelchair. M-A further indicated he did not believe there was a formal policy regarding this. R28's quarterly Minimum Data Set (MDS) dated 3/22/16, included a Brief Interview for Mental Status (BIMS) score of 3, indicating severely impaired cognition. The MDS further indicated the resident required extensive assistance with all activities of daily living. On 5/16/16, at 4:17 p.m. R28 was observed	21685		

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21685	Continued From page 34	21685		

sitting in her wheelchair (w/c) in her room. The armrests on the w/c were observed with tears with jagged edges along the outer edge of each armrest exposing the foam padding underneath. The right armrest also had a round circular area on the top of the armrest where the vinyl was missing exposing the foam padding underneath.

When interviewed on 5/18/16, at 9:46 a.m. the maintenance supervisor (MS) stated when maintenance issues are identified, staff are to write them down on a clipboard located at the nurses station. MS further stated he checks the list several times throughout the day when working. MS stated being unaware of any issues with R28's w/c as he had not been informed verbally by staff nor had it been identified on his maintenance list. MS and surveyor observed the list located on a clipboard at the nurses station and confirmed R28's torn w/c armrests had not been added to the list. MS and surveyor proceeded to R28's room. Upon observation, MS acknowledged that R28's w/c armrests need replacing and confirmed the jagged edges could cause skin tearing as well as not being a cleanable surface. MS stated he depended upon the staff to let him know about w/c issues as he does not audit the w/c's for maintenance concerns. MS further stated the night staff are responsible for cleaning of the w/c's and should have identified and brought R28's torn w/c armrests to his attention.

SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could work with the director of maintenance to develop a maintenance program to ensure wheelchairs are maintained in a safe and clean appearance. The DON or designee could develop a monitoring system to ensure

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21685	Continued From page 35 ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685		
21910	MN St. Statute 144.651 Subd. 25 Patients & Residents of HC Fac.Bill of Rights Subd. 25. Financial affairs. Competent residents may manage their personal financial affairs, or shall be given at least a quarterly accounting of financial transactions on their behalf if they delegate this responsibility in accordance with the laws of Minnesota to the facility for any period of time. This MN Requirement is not met as evidenced by: Based on interview and documentation review the facility failed to provide quarterly statements to residents and/or the legal representative for 16 of 45 residents (R46, R2, R16, R38, R1, R40, R41, R3, R11, R43, R5, R28, R18, R22, R29, R27) whose personal funds were managed by the facility. Findings include: On 5/17/16, at 8:35 a.m. R46's family member stated resident has a personal fund account with the facility but had never received a quarterly statement of money balance. On 5/17/16, at 3:20 p.m. R46's personal fund account was verified and reviewed with facility receptionist (R)-B. It showed a balance of $50.00 on 5/1/16. No debits or credits were noted on the account ledger.	21910		

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21910	Continued From page 36 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 their personal funds account. She further confirmed they would only provide a statement to the resident and/or the representative if there had been activity in the account during the month but did not send quarterly statements. R-B stated she was unaware of the requirement related to quarterly personal fund statements to all residents/responsible parties. Sixteen residents (R46, R2, R16, R38, R1, R40, R41, R3, R11, R43, R5, R28, R18, R22, R29, R27) had personal fund accounts with the facility and routine quarterly statements were not sent. A policy related to personal fund accounts was requested but not provided. SUGGESTED METHOD OF CORRECTION: The Administrator or designee could create policies and procedures related to financial management of resident accounts to ensure quarterly statements are provided to residents. Quality assurance committee could audit for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21910		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult	21980		

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21980	Continued From page 37 has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section	21980		

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	00576	A. BUILDING: _____ B. WING _____	05/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

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21980	Continued From page 38 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 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. Findings include: Staff failed to follow their policy related to the investigation, immediate reporting to the administrator and to the SA when R28 had an injury of unknown origin. R28 had diagnoses according to the physician orders dated 4/7/16, which included: dementia, major depression, psychosis, anxiety and Alzheimer's disease. R28's quarterly Minimum Data Set (MDS) assessment, dated 3/22/16, identified R28 had a Brief Interview for Mental Status (BIMS) score of 3 which indicated severe cognitive impairment. The MDS further identified R28 required extensive assistance of one staff with all activities of daily living (ADL's). During review of facility incident reports it was noted on 12/25/15, R28 had a fall with significant injury. The details of the fall documented on the incident report, dated 12/25/15, at 10:04 p.m. indicated R28's alarm was heard sounding by staff and when staff entered the room, R28 was found lying on the floor in her room on her right side in front of her recliner. R28's head was	21980		

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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 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 provider.

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 the State agency when R48 experienced an injury of unknown origin.

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21980	Continued From page 40	21980		

R48 had diagnoses that included: Alzheimer's disease, dementia with behavioral disturbance, fibromyalgia, and osteoarthritis per the signed physician's orders dated 4/12/16.

R48's 14-day Minimum Data Set (MDS) assessment, dated 4/3/16, identified R48 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated severe cognitive impairment. The MDS further identified R48 required extensive assistance of one staff with all activities of daily living (ADL's).

During review of R48's incident reports it was noted on 3/17/16, R48 had an unwitnessed fall with significant injury. The details of the fall identified on the incident report dated 3/18/16, at 1:35 a.m. indicated the incident occurred on 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 the care plan was being followed. DON further confirmed the fall was unwitnessed and R48 was

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21980	Continued From page 41 unable to tell staff the circumstances related to the fall. The facility did not implement their Vulnerable Protection Plan revised 7/1/15, which included 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 is suspicious because of 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. (16.) IMMEDIATELY: means as soon as possible from the time of the initial knowledge that the incident occurred, has been received or after discovery of the incident. If staff becomes aware of a situation or incident where police, emergency, medical services or protective services should be involved ASAP, the facility should call 911 first and then report to the MDH immediately. The policy further included under identification: (A.) Staff is to notify Administrator IMMEDIATELY concerning any observations or witnessing of abuse, neglect, involuntary seclusion, maltreatment/mistreatment, unknown injury event or misappropriation of personal property administrator along with any patterns, trends or occurrences without interviewing the resident/alleged victim.	21980		

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21980	Continued From page 42 SUGGESTED METHOD OF CORRECTION: The administrator or designee could provide education and training regarding responsibilities of staff, to ensure injuries of unknown origin and allegations of abuse are thoroughly investigated and reported to the State agency and administrator immediately. All incidents could be audited and the results reported to the quality assurance committee for further review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21980		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to implement their Vulnerable Adult policy to ensure the investigation and immediate reporting of allegations of abuse and/or injuries of unknown origin to the administrator and to the State Agency (SA) for 2 of 5 resident incidents (R28 & R22) reviewed. Findings include:	21995		

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21995	Continued From page 43 The facility did not implement their Vulnerable Protection Plan revised 7/1/15, which included 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 is suspicious because of 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. (16.) IMMEDIATELY: means as soon as possible from the time of the initial knowledge that the incident occurred, has been received or after discovery of the incident. If staff becomes aware of a situation or incident where police, emergency, medical services or protective services should be involved ASAP, the facility should call 911 first and then report to the MDH immediately. The policy further included under identification: (A.) Staff is to notify Administrator IMMEDIATELY concerning any observations or witnessing of abuse, neglect, involuntary seclusion, maltreatment/mistreatment, unknown injury event or misappropriation of personal property administrator along with any patterns, trends or occurrences without interviewing the resident/alleged victim. Staff failed to follow their policy related to the investigation, immediate reporting to the administrator and to the State agency when R28	21995		

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21995	Continued From page 44	21995		

had an injury of unknown origin. R28 had diagnoses according to the physician orders dated 4/7/16, which included: dementia, major depression, psychosis, anxiety and Alzheimer's disease.

R28's quarterly Minimum Data Set (MDS) assessment, dated 3/22/16, identified R28 had a Brief Interview for Mental Status (BIMS) score of 3 which indicated severe cognitive impairment. The MDS further identified R28 required extensive assistance of one staff with all activities of daily living (ADL's).

During review of facility incident reports it was noted on 12/25/15, R28 had a fall with significant injury. The details of the fall documented on the incident report, dated 12/25/15, at 10:04 p.m. indicated R28's alarm was heard sounding by staff and when staff entered the room, R28 was found lying on the floor in her room on her right side in front of her recliner. R28's head was 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

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21995	Continued From page 45	21995		

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 provider.

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 the State agency when R48 experienced an injury of unknown origin.

R48 had diagnoses that included: Alzheimer's disease, dementia with behavioral disturbance, fibromyalgia, and osteoarthritis per the signed physician's orders dated 4/12/16.

R48's 14-day Minimum Data Set (MDS) assessment, dated 4/3/16, identified R48 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated severe cognitive impairment. The MDS further identified R48 required extensive assistance of one staff with all activities of daily living (ADL's).

During review of R48's incident reports it was noted on 3/17/16, R48 had an unwitnessed fall with significant injury. The details of the fall identified on the incident report dated 3/18/16, at

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21995	Continued From page 46 1:35 a.m. indicated the incident occurred on 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 the care plan was being followed. DON further confirmed the fall was unwitnessed and R48 was unable to tell staff the circumstances related to the fall. SUGGESTED METHOD OF CORRECTION: The administrator or designee could provide education and training regarding responsibilities of staff, to ensure injuries of unknown origin and allegations of abuse are thoroughly investigated and reported to the State agency and administrator immediately. All incidents could be audited and the results reported to the quality assurance committee for further review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21995		