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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: QMQM

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00109

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245465**

2.STATE VENDOR OR MEDICAID NO.
(L2) **668340100**

3. NAME AND ADDRESS OF FACILITY
(L3) **COMMUNITY MEMORIAL HOME**
(L4) **410 WEST MAIN STREET**
(L5) **OSAKIS, MN** (L6) **56360**

4. TYPE OF ACTION: **7**

1. Initial
2. Recertification
3. Termination
4. CHOW
5. Validation
6. Complaint
7. On-Site Visit
9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

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

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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):
Facility's request for a continuing waiver involving K067 is approved.

17. SURVEYOR SIGNATURE — Date :
Mary Rogers, HPR Social Work — 12/16/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 12/22/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30) **00**

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 12/28/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/30/2015
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

CMS Certification Number (CCN): 245465
December 22, 2015

Mr. David Carlson, Administrator
Community Memorial Home
410 West Main Street
Osakis, Minnesota 56360

Dear Mr. Carlson:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective November 24, 2015 the above facility is certified for or recommended 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,

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

MDH
Minnesota
Department
of Health

Electronically delivered
December 22, 2015

Mr. David Carlson, Administrator
Community Memorial Home
410 West Main Street
Osakis, Minnesota 56360

RE: Project Number S5465026

Dear Mr. Carlson:

On November 2, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 15, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 16, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 4, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 15, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 24, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 15, 2015, effective November 24, 2015 and therefore remedies outlined in our letter to you dated November 2, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245465	A. Building B. Wing	12/16/2015

Name of Facility	Street Address, City, State, Zip Code
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0170** Reg. # **483.10(i)(1)** LSC	Correction Completed **11/24/2015**	ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **11/24/2015**	ID Prefix **F0248** Reg. # **483.15(f)(1)** LSC	Correction Completed **11/24/2015**
ID Prefix **F0250** Reg. # **483.15(g)(1)** LSC	Correction Completed **11/24/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **11/24/2015**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **11/24/2015**
ID Prefix **F0313** Reg. # **483.25(b)** LSC	Correction Completed **11/24/2015**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **11/24/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **11/24/2015**
ID Prefix **F0327** Reg. # **483.25(j)** LSC	Correction Completed **11/24/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **11/24/2015**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **11/24/2015**
ID Prefix **F0520** Reg. # **483.75(o)(1)** LSC	Correction Completed **11/24/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	JS/KJ	12/22/2015	29437	12/16/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 10/15/2015

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245465	A. Building B. Wing 01 - MAIN BUILDING 01	12/4/2015

Name of Facility	Street Address, City, State, Zip Code
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0067	11/24/2015	ID Prefix Reg. # NFPA 101 LSC K0072	11/24/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By TL/KJ	Date: 12/22/2015	Signature of Surveyor: 27200	Date: 12/04/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 10/20/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245465	A. Building B. Wing 02 - 2 BLDG PT/OT WELLNESS CENTER	12/4/2015

Name of Facility	Street Address, City, State, Zip Code
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0067	11/24/2015	ID Prefix Reg. # NFPA 101 LSC K0072	11/24/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	TL/KJ	12/22/2015	27200	12/04/2015
CMS RO				

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/20/2015				

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: QMQM

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00109

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245465**

2.STATE VENDOR OR MEDICAID NO.
(L2) **668340100**

3. NAME AND ADDRESS OF FACILITY
(L3) **COMMUNITY MEMORIAL HOME**
(L4) **410 WEST MAIN STREET**
(L5) **OSAKIS, MN** (L6) **56360**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/15/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B***, 5 (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):
Facility's request for a continuing waiver involving K067 is recommended.

17. SURVEYOR SIGNATURE — Date :
Austin Fry, HFE NE II — 11/13/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 11/25/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
AW K67 notification sent to Rochi 11/30/2015

Posted 11/30/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
November 2, 2015

Mr. David Carlson, Administrator
Community Memorial Home
410 West Main Street
Osakis, Minnesota 56360

RE: Project Number S5465026

Dear Mr. Carlson:

On October 15, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Jessica Sellner, Unit Supervisor
Minnesota Department of Health
Health Regulation Division
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7343
Fax: (320)223-7348

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 November 24, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by November 24, 2015 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by January 15, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 15, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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, Deputy State Fire Marshal
Health Care Fire Inspections
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
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Health Regulation Division
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Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING _____ B. WING _____	10/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(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. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 170 SS=C	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility fail to ensure resident mail was delivered promptly to residents on the weekend. This had potential to affect all 38 residents currently residing in the facility. Findings include: R34's quarterly Minimum Data Set (MDS) dated 9/3/15, identified R34 had no cognitive impairment. During interview on 10/13/15, at 12:19 p.m. R34	F 170	F170 - Right to Privacy □ Send/Receive Unopened Mail - By 11-24-15, the Activities Director will ensure that all resident mail is distributed to residents Monday through Saturday in accordance with established facility policy. The Activities Director or his designee(s) will, beginning Monday November 9, 2015, audit mail delivery procedures every Monday morning to make sure that no other residents are/were affected by this deficient practice. These weekly audits will be documented. To ensure future	11/24/15

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

Electronically Signed | 11/11/2015

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F 170	Continued From page 1 stated mail was not delivered to the residents on Saturdays because the business office was closed on the weekends. R34's care plan dated 4/11/13, indicated, "Mail will be delivered per U.S. Postal Service schedule / policy. Activity Staff will individualize assistance with mail." During interview on 10/14/15, at 2:25 p.m. the activities director (AD) stated the U.S Postal Service delivered mail on Saturdays to the facility nurses station, but the mail is held there until Monday morning when the business office was opened. AD stated the resident's Saturday mail was sorted on Monday, with the regular Monday mail which was then delivered to resident on Monday. A facility policy regarding resident mail delivery was requested but not provided.	F 170	compliance, the facility Social Worker will verify that these corrective actions have been taken each month for a period of one year from the completion date. Furthermore, the Activity Director or his/her designee will, by November 10, 2015, bring his/her findings to the QA committee for further consideration and inquire about Monday thru Saturday mail delivery each month at scheduled resident council meetings. Feedback from the Resident Council will be documented in their monthly meeting minutes. Completion Date: November 24, 2015	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents (R22) reviewed for environmental concerns had	F 246	F246 □ Reasonable Accommodation of Needs/Preferences - On 11/2/15 call light audits were initiated that would be	11/24/15

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F 246	Continued From page 2 access to their call light at all times. Findings include: R22's physicans progress notes, from 7/15/15, indicated the resident had the diagnoses including deaf, non-speaking, and blind. R22's annual Minimum Data Set (MDS) dated 10/01/15 indicated the resident was dependant on staff assistance with all activities of daily living and had severe cognitive impairment. The Care Area Assessment (CAA) dated 10/1/15, regarding communication indicated R22 communicated with, "Vocalizations, facial expression, touching palm means meds, and touch of hair is bathing." R22's Care Plan dated 1/17/12, directed staff, "Encourage use of call light to summon staff help. Place call light in her hand, or physically show her placement of call light." During observation on 10/13/2015, at 6:45 p.m., R22 was sitting in her room in the recliner facing the door. R22's call light was coiled up in the middles of her bed, approximately 2 feet from where she sat. R22's call light remained out of reach untit approximently 8:05 p.m., when staff came to assist for evening cares. During observation on 10/14/2015, at 8:18 a.m. R22 was again noted to be sitting in her room recliner. R22's call light was on the floor, between the wall and the head of the bed, which was approximately 6 feet away from the resident. During interview on 10/14/15, at 8:20 a.m. nursing assistant (NA)-C stated R22's call light should not of been on the floor and should be within in her reach. NA-C stated R22 did not	F 246	completed daily for 14 days on the affected resident (R22) to ensure that a call light was being placed within her reach. Upon completion of the 14 day audits, 2 times weekly audits will then continue for 10 weeks. Call light audits will be completed on all residents of the SNF one time weekly for four weeks and then, at random and to ensure future compliance, call light audits of 5 residents a week for 8 weeks will be completed. The Call light policy was reviewed and updated as of 11-9-15. Completed random audits will be reviewed by the IDT and QA committee at their next scheduled meetings. The Call Light Policy will be reviewed with nursing staff at the meeting being held with them on November 19, 2015. In addition, the Call Light Policy will be reviewed with all other staff members at the full staff meeting being held on November 20, 2015. Completion Date: November 24, 2015	

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F 246	Continued From page 3 always use her call light, however, it still should have been in reach for her use. NA-C stated that R22 had been assitsted back to her room, after completing breakfast at 7:50 a.m.. During interview on 10/14/2015, at 11:30 a.m. the director of nursing (DON) stated call lights should be in reach of all resident that have the ability to use them. DON stated she had spoken to staff regarding R22's ability to use the call light, and R22 was able to activate the call light for assistance.	F 246		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure 3 of 5 residents (R22, R19, and R16) reviewed for activities were provided activities as directed by their individualized comprehensive assessment. Findings include: R22's facesheet identified R22 had diagnoses of being deaf, non-speaking, and blind. R22's annual Minimum Data Set (MDS) dated 10/01/15, identified R22 was rarely understood by others, had severe vision and hearing loss, and	F 248	F248 □ Activities Meet Interests/Needs of Each Resident - In order to ensure that each resident receives services with reasonable accommodations of individual needs and preferences, the R.N. Case Manager completed, by November 6, 2015, informal assessments of the affected resident□s (R22) auditory capabilities by using multiple kinds of screens of her hearing. All screens confirmed that the resident was unable to hear, but that she sensed low frequency vibrations through her hands. These findings were communicated to Activities	11/24/15

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F 248	Continued From page 4 had interests which included group and music activities. The MDS indicated it was "somewhat important" for R22 to attend her favorite activities. R22's communication Care Area Assessment (CAA) identified R22 communicated with "vocalizations, facial expression, touching palm means meds, and touch of hair is bathing." An activity CAA was not trigger for completion by the MDS. During multiple observations on 10/12/15, (12:50 p.m. - 4:30 p.m., 10/13/15, from 11:45 a.m. - 8:00 p.m., 10/14/15, from 6:45 a.m. - 3:00 p.m., and 10/15/15, from 8:00 a.m. - 11:30 a.m.), R22 was seated in her recliner chair facing the room doorway. The recliner was against the window wall with the foot of her bed to her right. R22 was not observed to participate in any of the facility activities during these periods. R22's Activity Review dated 4/30/15, identified R22 preferred live music in the Current Activity Review section. R22's activities care plan dated 2/9/12, identified R22 had, "Very limited involvement in supervised/organized recreation related to: her diagnosis of hearing loss [deaf] and lack of vision." The care plan directed staff to encourage R22's attendance at group activities and offer R22 musical opportunities of live music. During observation on 10/12/15, the facility had a live music group at 3:00 p.m. that was approximately one hour. During this activity, R22 remained in her room sitting in her recliner. During interview on 10/14/15, at 8:44 a.m. activity	F 248	staff for immediate inclusion into her activities programming care plan. Family members of other potentially affected residents were called and offered appointments for audiology consults regarding their hearing abilities. Results of screens and assessments completed on all residents before their next scheduled care conference will be used by Activities staff to tailor their programming in ways that meet individual needs and preferences. R19, R16 and R22 will have their care plan reviewed by November 24, 2015 to ensure that they are offered more individualized and meaningful activities. The Activities Director will review and modify the PointClickCare charting system to better identify residents who require adaptations and more individualized approaches to meeting their needs. Current program offerings and choices will be modified to reflect needs that are identified. To ensure future compliance, the Activities Director or his designee will, upon admission for those who are unable to make their needs and preferences known, contact a resident representative who can inform staff of that resident□s current and former likes and dislikes. Activity preferences and approaches staff can take to meeting individual needs will be reviewed at quarterly care conferences beginning November 16, 2015 and at QA meetings, beginning November 10, 2015.	

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assistant (AA)-A stated family informed the facility R22 liked live music, and should encourage music program attendance. AA-A stated she was uncertain if R22 was hearing the music or just feeling the vibration produced by the source of sound. When asked if staff have ever attempted a Pocket-Talker (sound amplification device) with the resident, whether for verbal communication or music groups, AA-A stated not that she was aware of.

In a follow-up interview on 10/15/15, at 10:00 a.m., AA-A was asked about the facility's documentation system for Activity Attendance. AA-A stated with the computerized facility documentation program, the Activities Department had events grouped together in broad categories, such as General / Special Activities. AA-A stated the categorized sections have icons that can be clicked to more specifically indicate the activity attended, i.e.: 1:1 Visits. However, AA-A stated the program only documents the initials of the staff recording, the time, date, and the broad category the activity fell into, so there was no way to track exactly what activity's the resident specifically attended. AA-A stated the facility lacked documentation of what 1:1 activities were provided each date, whether R22 accepted, took part in, or rejected the activity provided. AA-A stated R22 liked music, and staff tried to get her to the 3 different live music groups on the 1st, 2nd and 4th Mondays of each month.

In review of R22's Activity Attendance Logs the following was documented as attended activities:

August 2015
> Physical Activity on 8/4, 8/6, and 8/7, 8/24, 8/28, and 8/31/2015 - this was documentation of R22

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F 248	Continued From page 6 walking to or from an activity. > General / Special Activities were documented 10 activities attended, one being live music, one a "Active Minds" group and the remaining 8 being 1:1 visits. > Media on 8/6/15, R22 attended a news group. September 2015 > Physical Activity documented 5 times of walking to or from an activity > General / Special Activities were documented 11 events which lacked indication of what was attended. October 1-12, 2015 > Physical Activity documented 5 times of walking to or from an activity. > General / Special Activities was documented only once on 10/12/15, at 9:30 a.m. - discussion group entitled Read and Remember. During interview on 10/14/2015, at 1:56 p.m. the activity director (AD) stated the facility utilized the MDS section F - Preferences for Routine & Activities as their comprehensive assessment, and also uses information from the residents families for prior preferences, if a resident is unable to communicate. AD stated they did not document acceptance and/or rejection of activities provided to residents. AD stated activity staff do not have a schedule of 1:1 visits, but openly discuss with each other during the week with who 1:1 have been completed and what activities were offered. R19's admission MDS dated 7/17/15, indicated R19 had severe cognitive impairment, and indicated the residents preferences for routine	F 248		

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and activities were: Likes to listen to music, spending time outdoors, and participating in religious activities or practices.

R19's Social history form dated 7/14/15 indicated R19 like cooking and gardening.

R19's care plan dated 10/12/15, indicated the resident required the assist of one staff with activities of daily living (ADL's), was non-ambulatory, and required the use of a mechanical lift for transferring from one surface to another. The care plan also indicated R19 liked the Wheel of fortune and Price is Right on television, and directed staff to assist R19 in watching these programs. The care plan directed staff of offer R19 musical opportunities of live entertainment.

R19's attendance activity log for August 2015, indicated R19 participated in general/special activities 16 times, and media four times that month. R19's attendance activity log for September 2015, indicated R19 participated in general/special activities 16 times and music two times. R19's attendance activity log for October 2015, indicated R19 attended general/special activities six times from 10/1/15, through 10/12/15.

An observation on 10/13/15, at 5:00 p.m. R19 was sitting in the bird aviary room in a Broda chair (tilt and recline positioning wheelchairs) with her eyes closed.

An observation on 10/13/15, at 6:11 p.m. R19 was sitting in the bird aviary area, holding a baby doll, and humming while in the Broda chair. Other residents were sitting in the room next door

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F 248	Continued From page 8 watching wheel of fortune on the television. An observation on 10/14/15, at 7:41 a.m. R19 was sitting in the Broda chair in R19's room facing the window and humming. An observation on 10/14/15, at 11:22 a.m. R19 was sitting in the bird aviary area with other residents and had her eyes closed. During interview on 10/13/15, at 6:41 p.m. nursing assistant (NA)-E stated R19 liked to hold a baby doll and listen to music to help her sleep. During interview on 10/15/15, at 9:01 registered nurse (RN)-C stated R19 listened to music, current events, but did not participate in hands on activities. During interview on 10/14/15, at 2:07 activities director (AD) stated staff try to take R19 for a walk when it is nice outside, and R19 liked music, one on one visits, and gardening in the summer. AD verified there was no system in place to indicate what activities R19 had participated in, there were only general categories. R16's quarterly MDS dated 7/9/15, indicated the resident had severe cognitive impairment, and required physical assist from staff to get to all destinations. R16's Care plan dated 10/15/15 indicated R16 would participate in activities of interest daily, or as scheduled. Staff was directed to assist the resident with mobility to and from activity location, and to encourage R16 attendance at group	F 248		

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activities of bingo and crafts. The care plan directed staff to offer R16 musical opportunities of live entertainment, offer interests of spiritual activities such as bible study and chapel, post activity calendar in R16's room, talk over the schedule of events each day to plan attendance, and offer social activities of snack/coffee break in the afternoon to visit with other residents.

A facility progress note dated 10/13/15, indicated R16, "Is generally quieter, she does not interact with her environment as she used to. She used to tell staff that someone needed help, or would sit by certain residents to hold their hands. She does not attend many activities, as has been her pattern for years. If she agrees, she often sits on the edges of the activity."

An Admission Activity Review dated 2/20/14, listed R16's hobbies as gardening and quilting, live music, general crafts, bingo, television, movies, going to chapel, and bible study.

During observation on 10/12/15, at 2:57 p.m. R16 was sitting in her wheel chair in front of the bird aviary by the main entrance of the facility. A live musical program was occurring at the same time in the dining room. R16 was humming and stated, "They are singing, I can't hear him." At 3:29 p.m., staff escorted R16 to the music program as it was near completion.

During observation on 10/13/15, at 6:13 p.m., R16 was sitting in her wheel chair in front of the bird aviary where she remained for the next thirty minutes. R16 was looking around, but not engaged in the birds. During this time, in another common area, several resident's were watching Wheel of Fortune on television.

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During observation on 10/13/15, at 7:53 p.m. R16 was observed sitting in her room facing the wall. There was no television on, no music playing, and no one else was present in the room.

During observation on 10/14/15, at 8:42 a.m. R16 was wheeled in her wheelchair by staff from the dining room and placed in front of the bird aviary where she was again observed at 9:23 a.m., asleep in her wheel chair.

On 10/14/15, at 2:07 p.m. R16 was again observed sitting in her wheel chair in front of the bird aviary while bingo was in progress in another area of the facility.

A review of a facility activity attendance log from 9/12/15, to 10/12/15, indicated R16 attended spiritual activities two times, music activities 5 times, did not go on any outings, and did not attend any craft activities or games, however, the residents activity assessment indicated the resident enjoyed spiritual activities, group activities, bingo, and crafts.

During interview on 10/14/15, at 2:09 p.m. NA-A stated R16 used to like to sew but has not done that in years. NA-A stated staff will try to bring R16 to music and to watch the "church ladies" cut up vegetables in the summer. NA-A stated R16 used to help fold napkins, but can't remember how to do this anymore. Also, staff no longer take her to bingo because she can't see the bingo card.

During interview on 10/15/15, at 9:51 p.m. activity director (AD) stated staff check with R16 every time they have activities, and R16 would tell staff

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F 248	Continued From page 11 if she did not want to go to an activity. AD stated R16 liked bingo, however, she had not played much in the last six months. The AD stated she reviewed R16's activity attendance and the resident had not refused any activities in the last month.	F 248		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the social worker failed to comprehensively assess and develop interventions to reduce symptoms of worsening depression for 1 of 1 residents (R36) who experienced ongoing sadness about being unable to return home. Findings include: R36's quarterly Minimum Data Set (MDS) dated 9/24/15, identified R36 had moderate cognitive impairment, and had no recorded signs or symptoms of depression. During interview on 10/13/15, at 12:22 p.m. R36 stated she often feels lonely and "not really" happy since coming to the nursing home, and she was upset because staff didn't take the time to visit with her. R36 became teary eyed and wiped	F 250	F250 □ Provision of Medically Related Social Service - A Care Conference was held with the affected resident (R36) and her family on 10/16/15. Discussion of discharge planning and resident□ R36's mood was reviewed with all parties attending. Resident R36 was added to focus charting on 11/3/15 to specifically address her mood per shift by the licensed staff member working with the resident (R36). On 10/16/15, CNA□s began task charting specifically for sadness/tearfulness, statements of wanting to die, and statements of feeling down. Social Worker began one-to-one visits weekly starting 11/2/15 and will continue for 8 weeks. Upon completion of the 8 weeks, the Social Worker will visit with the resident (R36) to see if she wants one-to-one visits extended. Social worker	11/24/15

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F 250	Continued From page 12 her face with a tissue, and stated it was difficult to leave her home and now live in, "Just one room" in a nursing home, adding "[but] what can I do?" R36's care plan dated 10/27/14, identified R36 had "Potential for ineffective individual coping R/T [related to] new placement in nursing home...upset that [R36] cannot go home due to medical needs." The care plan directed "Social Services, Observe for s/s [signs and symptoms] depression...", and complete, "One to one visits as needed or requested." The last revision completed on R36's care plan to address her feelings of depression, sadness, and poor coping was 11/27/14 (nearly one year prior). During observation on 10/13/15, at 5:28 p.m. R36 was seated in the dining room at a table with other residents. The registered dietician (RD)-A approached R36 and began to converse with her. R36 told RD-A there was, "No place like home," and she would like to return there placing her hands on the side of her head. R36 told RD-A stories about living at home until 5:32 p.m. (4 minutes later) when RD-A stood up and told R36 she had to get back to work and left the table. At 6:05 p.m. R36 finished her supper meal and was self propelling her wheelchair in the hallway when two un-identified visitors approached R36 and began to converse with her. R36 told the visitors she wanted to go home, "I hope and pray someday I can go back home." R36's progress note dated 4/30/15, indicated, "...Still talks about not being able to go home, but she seems more accepting of her need to have 24 hr [hour] care." An additional progress note dated 7/23/15, identified R36, "Still talks about not being able to go home and grieves the need to	F 250	will review task and focus charting on resident R36 at the end of the 8 weeks. Will review findings with IDT. Will also complete a PHQ-9 if signs and symptoms of depression have increased. Discharge planning will continue to be discussed with resident R36 and her family at quarterly care conferences since the resident (R36) stated she knows she is unable to return home right now. To prevent this deficient practice from affecting other residents, discharge planning will be discussed each quarter with the resident and his/her family to see if they are interested in pursuing a return to the community. If any resident expresses a desire to return to community living, the Social Worker will assist with discharge planning and involving outside referral sources. A PHQ-9 will be completed per the MDS schedule on each resident in-house. If the score is indicative of depression per the Mood Policy or if the resident indicates depression, a repeat PHQ-9 will completed within 1 week. If the score continues to remain high, the Social Worker will complete weekly visits for 8 weeks. Task and focus charting will be started for 2 weeks and will then be reviewed to see if further follow-up is needed. The facility□s Mood/Behavior and Review Management Policy will be reviewed and updated by November 18, 2015. Nursing staff will be educated on the policy at their meeting scheduled for November 19, 2015. All other staff will be educated on when and how to report noted mood changes at the full staff meeting	

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F 250	Continued From page 13 live out her life in a facility, but [R36] recognizes her need for 24 hour care and assistance." However, the progress notes lacked any plan or interventions to reduce R36's feelings of loss and sadness of having to live in a care facility. R36's most recent Mood-Behavior Review dated 9/20/15, identified R36 had, "A couple episodes of feeling down and depressed, but had no mood or behaviors charted in the past 30 days." The interventions used to manage R36's mood were identified as, "Allow resident to voice her feelings and express concerns with 1:1 visit, Invite [sic] her to attend facility activities, Give [sic] redirection, and provide distraction. Ask her to remince [sic] about her life on the farm. Ask about her interest with sewing and needle point." The review identified these interventions were effectively managing R36's mood and behaviors, and staff would continue to monitor and update PCP [primary care plan] as needed. During interview on 10/14/15, at 12:54 a.m. nursing assistant (NA)-D stated R36 admitted to the facility for rehabilitation, but was now there for long term care. NA-D stated R36 seemed more sad and depressed lately, often expressing her desire to return home several times to her, and NA-D stated she let the nurses know about the increase in R36's sadness. NA-D was unaware what had been done to help R36 manage her feelings adding and stated the nursing staff were the only support R36 had. During interview on 10/15/15, at 8:12 a.m. licensed social worker (LSW)-A stated R36 will focus on things from her past. LSW-A stated upon admission R36 had a goal of returning home, and was started on Celexa (an	F 250	scheduled for November 20, 2015. Completion Date: November 24, 2015	

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F 250	Continued From page 14 anti-depressant medication) shortly after admission because "she was so weepy." LSW-A last visited with R36 on 7/1/15, and documented she had, "No signs of depression at this time." LSW-A tried to complete as much positive reinforcement as she can for R36, but was unaware the staff were seeing signs R36 was having increased sadness about not being able to return to her home as it had not been reported to her. LSW-A stated, "They [staff] should report if somebody is having a change in their mood." Further, LSW-A stated she would have increased her assessments and visits to help R36 manage her feelings of depression and sadness as reported by the nursing staff, but she was unaware of the concerns. A facility Mood/Behavior Review and Management policy dated 5/15/14, identified, "The facility will review target behaviors on residents to assure that appropriate care and interventions for those residents are being implemented." Licensed staff or Social Services will initiate daily target mood/behavior monitoring...for those residents with mood/behavior concerns."	F 250		
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.	F 309		11/24/15

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F 309	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to adequately monitor and reassess hearing to ensure effective communication for 1 of 1 residents (R22) reviewed who had sensory deficits. In addition, the facility failed to ensure follow up, assessment, and monitoring of skin impairment to ensure adequate healing for 1 of 2 residents (R27) reviewed for skin concerns. Findings include: R22's medical record facesheet indicated resident had the diagnoses of deaf, non-speaking and blind. R22's annual minimum data set (MDS) dated 10/01/15, indicated the resident had severe cognitive impairment, was never or rarely understood, was dependant on staff with all activities of daily living, nor had R22's vision and hearing been evaluated due to severe vision, verbal communication, and hearing loss. R22's Care Area Assessment (CAA) regarding communication indicated R22 communicated with "vocalizations, facial expression, touching palm means meds, and touch of hair is bathing." During multiple observations during survey, on 10/12/15 (12:50 p.m. - 4:30 p.m., 10/13/15 from 11:45 a.m. - 8:00 p.m., 10/14/15 from 6:45 a.m. - 3:00 p.m., and 10/15/15 from 8:00 a.m. - 11:30 a.m.) R22 was observed sitting in her recliner facing the room doorway. The recliner was against the window wall with the foot of her bed to her right.	F 309	F309 Provide Care/Services for Highest Well Being - R22s hearing was assessed by the RN Case Manager on 11/4/15. A corresponding nurses note was written that indicated findings of that assessment and the residents care plan was reviewed and updated. A referral to audiology was offered to her guardian and subsequently declined. To prevent this deficient practice from affecting any other residents, licensed staff will contact all residents or their responsible parties by 11/20/15 to offer an audiology referral. Hearing policy was created on November 9, 2015. Hearing assessments will be completed by an R.N. on all residents according to their next assessment reference date (ARD). The new policy will be reviewed at the nurses meeting scheduled for November 19, 2015. Annual hearing assessments will be completed with full MDS assessments, upon admission, or as needed. Staff will be offering audiology referrals at least annually and as needed in the future. Completion Date: November 24, 2015 Regarding the deficient practice with R27, our RN assessed the wound which was assessed earlier as healed on 10/15/15, the RN Case manager reassessed her bilateral feet on 11/4/15 which, again, indicated no skin concerns. R27 was counseled by the RN Case Manager on 11/4/15 regarding footwear. R27 was agreeable to start wearing tennis shoes. The care plan was adjusted to reflect the wearing of tennis shoes. To identify all	

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F 309	Continued From page 16 During interview on 10/12/15, at 4:10 p.m. registered nurse (RN)-C stated R22 is not able to communicate her needs clearly and is only able to make non-discernable sounds. RN-C stated R22 has an unknown level of retained hearing ability, and severely limited vision. RN-C stated staff provide tactile (touch) stimulation for instructing resident what to do and where they want her to go. RN-C stated staff rely on nonverbal communication, such as pulling away, if R22 had not accepted the activity encouraged by staff. During interview on 10/14/15, at 8:18 a.m. nursing assistant (NA)-C stated staff are uncertain if R22 can hear if anything, and staff communicate with the resident by touch, placing items (i.e.: hair brush) in R22's hand, and grasping the resident's hand to take her to meals and activities. During interview on 10/14/15, at 8:44 a.m. activity assistant (AA)-A stated family informed the facility R22 liked live music, and activity staff should encourage R22 to attend music programs. AA-A stated she was uncertain if R22 heard the music or just felt the vibration produced by the source of sound. AA-A stated she was not aware the facility had ever attempted to use a Pocket-Talker (sound amplification device) with R22 for verbal communication or during music activities. R22's care plan regarding communication dated 10/12/12, indicated R22 had sensory concerns related to impaired verbal communication, hearing, and vision. The care plan indicated R22's family "assumed" the resident see's very	F 309	residents who had potential to be affected by this deficient practice, the RN completed skin audits on all residents to ensure all current skin issues are documented and on the UDA board. To ensure future compliance, the UDA board will be brought to stand up for review. The Wound Management Skin Integrity policy and procedure will be reviewed by all licensed staff at their meeting on November 19, 2015. The incident/accident form was updated to include assessment and treatment prompts. The DON and Administrator will sign off once that form is completed. Completion Date: November 24, 2015	

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little. R22 was identified R22 as having high safety and vulnerability issues due to her sensory deficits, and instructed staff to be, "Alert to nonverbal indicators from [R22] that she is fearful, anxious."

In review of both R22's paper and electronic medical records, there was no indication the facility had ever sought or inquired when R22 last had a hearing evaluation to determine what the resident was able to hear and or discern from the environment.

During interview on 10/14/2015, at 11:30 a.m. the director of nursing (DON), after review of R22's record, stated that family has declined vision exams, however there was no evidence that since admission in 2012, that R22 or her family have been offered the scheduling of a hearing evaluation.

R22's family was attempted to be reached on Wednesday 10/14/15, and Thursday 10/15/15, but was unavailable for interview.

R27's quarterly MDS dated 8/20/15, indicated the resident was cognitively intact, required assistance with activities of daily living, and was at risk for skin impairments.

R27's care plan dated 9/2/2015 indicated the resident had the potential for impaired skin integrity related to acute CVA (cerebral vascular accident) with left sided weakness and neglect. R27's care plan directed staff to observe for alterations in skin integrity.

R27's facility progress notes indicated staff

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reported R27 had a skin irregularity on 10/7/15. A Progress Noted dated 10/8/15 indicated, R27 "had a scant amount of blood on the skin on her left second toe with a bruise at the base of her toenail. A wound assessment dated 10/8/15, indicated bruising on R27's left toe with a wound appearance description was noted to be dark purple in color with an open area. Specific interventions included, "Continue to monitor daily and measure weekly with user designated assessment (UDA) until healed. Further review of R27's wound assessments indicate a history of skin alterations to her left foot including pressure ulcer and bruising.

During observation on 10/13/15, at 5:56 p.m. R27 was self- propelling herself in the wheel chair from the dining room to her room using her right foot; with her left foot resting on a foot pedal.

During observation on 10/14/15, at 7:04 a.m. R27 was sitting in the wheel chair in her room and was wearing open toe sandals.

During observation on 10/15/15, at 10:28 a.m. the 2nd toe of R27's left foot was noted to be bright red with black under the nail bed, and the toe appeared swollen.

During interview on 10/14/15, at 10:05 a.m. R27 stated she was not aware of what was wrong with her toe, but it had been, "bleeding on and off."

During interview on 10/15/15, at 8:43 a.m., licensed practical nurse (LPN)-A stated she was unaware R27 had a toe injury, and the facility had a weekly UDA board where staff look to see if any resident assessment is needed. LPN-A stated there was nothing in R27's treatment record

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F 309	Continued From page 19 directing staff to monitor the toe. During interview on 10/15/15, at 8:33 a.m. LPN-B stated she was not aware of any skin concerns for R27. During interview on 10/15/15, at 9:14 a.m. registered nurse (RN-A) stated she was unaware of R27's toe injury. RN-A reviewed R27's progress notes, and stated it appeared staff had discovered R27 had a bruise on her toe on 10/8/15. RN-A stated resident injuries were monitored by the nurse weekly until the area is healed and R27 was due for a follow-up by the nurse on the floor. RN-A stated the nurses looked at the "UDA board" for direction on which assessments are due, however, there was no information regarding R27's toe injury. The "UDA board" was observed and did not indicate any further follow up or assessment in relation to R27's toe injury. On 10/15/15, at 10:05 a.m. RN-B assessed R27's left second toe and stated there was no longer bruising present, however, she stated, "The left foot has more dependent edema, red, cooler to the touch than the right foot." RN-B stated the nail bed of R27's left second toe had dried blood in it, and had tried washing it but the blood didn't come off. RN-B palpated the nail bed and stated, "It's soft, she will probably lose the nail." In regard to intervention and prevention of further injury to R27's left foot, RN-B stated, "We encourage closed toed shoes, but it is her choice if she wants them." RN-B stated there was no documentation R27 received education regarding wearing open toed shoes and stated staff had just added that intervention to R27's care plan today,	F 309		

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F 309	Continued From page 20 10/15/15. During interview on 10/15/15, at 12:43 p.m. director of nursing (DON) stated, licensed staff do UDA's for all injuries, and once an injury is noted it gets documented on an incident report, goes into wound measuring in the computer, and is placed on the UDA board so it gets followed up on that week. DON stated if there is a history of injury to a certain area the facility will do education if appropriate and implement interventions to protect the areas with injury's. DON stated if a resident refuses an intervention, there should be documentation in the resident record of the refusal. A facility policy titled Community Memorial Home Wound Management/Skin Integrity/Ulcers dated 12/15/14, directed staff to document skin impairments at least weekly and to develop a plan of care to include interventions to preserve skin integrity. The policy further indicated If a resident refuses or resists staff interventions, the care plan should reflect efforts to seek alternatives as well as education to resident and/or family regarding the risks.	F 309		
F 312 SS=D	. 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		11/24/15

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F 312	Continued From page 21 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 ensure nail care was completed for 1 of 3 residents (R1) reviewed for activities of daily living (ADLs) and who were dependant on staff for assistance with cares. Findings include: R1's 30 day Prospective Payment System Minimum Data Set (MDS) dated 8/25/15, identified R1 had no cognitive impairment and required extensive assistance from staff to complete personal hygiene. During observation on 10/12/15, at 11:15 a.m. R1 was laying in bed in his room. R1 had visibly long fingernails on both hands, and several nails had a dark colored substance underneath them. R1 stated he needed staff assistance to trim his nails, and he would like them kept shorter. When observed on 10/13/15, at 11:43 a.m. and 10/14/15, at 9:00 a.m. R1 continued to have long, dirty fingernails. When interviewed on 10/14/15, at 12:29 p.m. nursing assistant (NA)-B stated R1 receives a weekly bed bath on Friday, and nail care should have been completed then. Further, NA-B observed R1's fingernails and stated they "look	F 312	F312 - ADL Care Provided for Dependent Residents- The resident that was affected by this deficient practice (R1) had his fingernails clipped and cleaned on 10/15/15. Resident R1's fingernails were, again, audited on 10/23/15, 10/30/15, and 11/3/15. All other residents at risk of being affected by this deficient practice had their fingernails checked (i.e. audited) for cleanliness and nail length to determine if they needed their nails clipped and/or cleaned on 11/3/15. To ensure future compliance, two random audits will be completed on nail care each day those residents receive their scheduled bath for 12 weeks, starting 11/9/15. The nail care policy was reviewed and updated on November 9, 2015 and it will be shared with nursing staff at their meeting that is scheduled for November 19, 2015. Licensed staff will perform nail care on all residents with a diagnosis of diabetes. Nail care for diabetic residents will be documented on the Treatment Administration Record (TAR). Nursing assistants will perform nail care on all other non-diabetic residents. Compliance with this deficient practice will be discussed and reviewed with the IDT and	

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F 312	Continued From page 22 long", and "could be cleaned." During interview on 10/14/15, at 12:37 p.m. licensed practical nurse (LPN)-B stated R1 was "pretty much" dependent on staff for his ADLs and care, and the licensed nurses complete his nail care as he was diabetic. At 12:46 p.m. LPN-B observed R1's fingernails and stated they could "definitely be cut", and should be cleaned. A facility Trimming Fingernails policy dated 11/2008, identified a licensed nurse should complete nail care for diabetic residents "after [their] weekly shower or bath."	F 312	QA teams at their future meetings. Completion Date: November 24, 2015	
F 313 SS=D	483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 residents (R22) with known hearing deficits was provided an opportunity for hearing evaluation. Findings include: R22's medical record facesheet indicated the	F 313	F313 □ Treatment/Devices to Maintain Hearing/Vision - On 11/3/15, a call was placed to the affected resident's (R22) responsible party with an offer to make an audiology referral. The responsible party returned this call on 11/5/15 stating that she does not want the resident (R22) to have an audiology appointment as they	11/24/15

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F 313	Continued From page 23 resident had the diagnoses of deaf, non-speaking, and blind. R22's annual Minimum Data Set (MDS) dated 10/01/15, indicated the resident had severe cognitive impairment, was rarely or never understood, was dependant on staff with all activities of daily living, and R22's vision and hearing had not been evaluated due to severe loss of vision, verbal communication, and hearing loss. R22's Care area assessment (CAA) for Communication indicated R22 communicated with "vocalizations, facial expression, touching palm means meds, and touch of hair is bathing." During multiple observations during survey, from 10/12/15, through 10/15/15, when not at meals, R22 was observed sitting in her room in the recliner facing the room doorway. The recliner was against the window wall with the foot of her bed to her right. During interview on 10/12/15, at 4:10 p.m. registered nurse (RN)-C stated R22 is unable to communicate her needs clearly and is unable to verbally express herself outside of non-discernable sounds. RN-C stated R22 had an unknown level of retained hearing ability, and severely limited vision. During interview on 10/14/15, at 8:18 a.m. nursing assistant (NA)-C stated staff are uncertain on how much R22 can hear; if anything. NA-C further stated staff communicate by touch, placing items (i.e.: hair brush) in R22's hand, and also grasp the resident's hand to take her to meals and activities.	F 313	have been to Mayo in the past and they said, "She is unable to hear anything". Regarding all other residents who are potentially affected by this deficient practice and by November 20, 2015, a call or visit will be made to each resident or their representative to offer an audiology referral. At least annually, each resident or resident representative will be offered the opportunity for an audiology referral. A policy and procedure regarding hearing assessment and referral was developed on November 9, 2015 and it is now in place to determine the need for hearing assessments upon admission, annually thereafter, and otherwise as needed. This new policy will be reviewed with licensed staff at the nurses meeting scheduled for November 19, 2015. The care conference template was updated to indicate that audiology referrals were offered. Completion Date: November 24, 2015.	

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F 313	Continued From page 24 R34's care plan (CP) for Communication last revised 10/12/12, indicated R34's sensory concerns in regards to impaired verbal communication, hearing, and vision. The CP indicated family, "Assumes that [R22] sees very little." The facility further identified R22 had "high" safety and vulnerability issues due to her sensory deficits, and the CP directed staff to be "alert to nonverbal indicators from R22 that she is fearful, anxious." In review of both R22's paper and electronic medical records, there was no indication the facility had ever sought or inquired family to when R22 last had a hearing evaluation to determine what the resident was able to hear and or discern from the environment. During interview on 10/14/2015, at 11:30 a.m. director of nursing (DON), after review of R22's record, stated she believed family had declined vision exams, however, there was no evidence since admission in 2012, R22 or her family had been offered the scheduling of a hearing evaluation. The family was attempted to be reached on Wednesday 10/14/15, and Thursday 10/15/15, but was unavailable for interview.	F 313		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that	F 315		11/24/15

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F 315	Continued From page 25 catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively reassess urinary incontinence for 1 of 3 residents (R37), who was frequently incontinent of bladder to ensure an individualized toileting program was implemented to maintain bladder function. Findings include: R37's admission Minimum Data Set (MDS) dated 4/10/15, indicated the resident had no cognitive impairment, was frequently incontinent of bladder, and required assistance from staff to manage toileting needs. The MDS further indicated R37 was not on a toileting program, nor had a trial toileting program been attempted. R37's Care area assessment (CAA) dated 4/101/5, for urinary incontinence indicated R37 had urinary urgency and indicated use of anticholinergic medications. (side effects of anticholinergic medications include difficulty with urination and constipation), and indicated improvement in urinary continence was the overall objective for R37 as it related to continence. R37's quarterly MDS dated 9/10/15, indicated she was cognitively intact, required extensive assist of one staff for transfers, and extensive assist of two	F 315	F315 □ No Catheter, Prevent UTI, Restore Bladder -The resident affected by this deficient practice, R37, had bowel and bladder data collection started on 11/2/15 that was completed, along with a resulting Bowel and Bladder Assessment, on 11/6/15. An individualized toileting plan was created following completion of the bowel and bladder and a fall assessment on 11/6/15. To identify others who may be affected by this deficient practice, all residents will have a bowel and bladder assessment completed with their next quarterly MDS to determine appropriateness for a toileting program. To achieve systemic change and ongoing compliance, the bowel and bladder policy and toileting program will be reviewed at the meeting for licensed staff that is scheduled for November 19, 2015. Furthermore, all incidents, accidents, and changes in resident health as they relate to toileting will be discussed at stand-up to determine the need for further assessment. Trends will be brought to the attention of weekly IDT and quarterly QA meetings for further discussion, program refinement, and need for assessment. To ensure effectiveness all incidents/accidents/health changes are	

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F 315	Continued From page 26 staff for toileting. R37's MDS indicated she remained frequently incontinent of bladder, was not on a toileting program, nor had a trial toileting program been attempted. R37's Bowel and Bladder assessment dated 4/10/15 indicated R37 was able to identify the urge to void, was able to use the call light, had short term memory loss, required assistance with ambulation, transfers, and displayed symptoms of urinary urgency. The treatment plan outlined in R37's Bowel and Bladder assessment indicated a, "Scheduled/habit toileting plan," which was described as "Scheduled toileting at regular intervals on a planned basis to match voiding habits. R37's Care plan dated 9/25/15, indicated R37 required assistance to restore function to maximum self sufficiency for toileting, urinary incontinence, and bowel continence. Staff were directed to transfer R37 with assist of one staff to and from toilet at her request, and to offer assistance every two hours. R37's care plan further indicated R37 may request to "sit awhile" on the toilet and directed staff to check on her often and to remind her how long she had been there. The care plan directed staff to encourage R37 to limit her toileting time to 30 minutes or less. During observation on 10/13/15 at 6:56 p.m., a staff member was observed running down the hall in response to an alarm sounding in R37's bathroom where R37 was attempting to self transfer to the toilet. During interview on 10/14/15, at 12:31 p.m.	F 315	discussed at morning IDT meetings and will include the need for a bowel and bladder assessment to be completed. Completion Date: November 24, 2015	

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nursing assistant (NA)-A stated R37 was incontinent of bladder, and R37 attempted to take herself to the bathroom and R37 is forgetful and forgets that she needs staff assistance.

During interview on 10/14/15, at 12:47 p.m., registered nurses (RN)-A stated R37 had some continence of urine, and R37 had been consistent with her level of incontinence. RN-A stated there were no specific assessment completed to establish patterns of incontinence to determine an individual toileting plan, and stated, "Most of our people [residents] are every two hours [toileting schedule]." RN-A stated she was unable to provide documentation of R37's voiding habits, and stated bladder assessments are done upon admission and annually.

During an interview on 10/14/15, at 1:07 p.m., director of nursing (DON) stated upon admission staff should have gotten a history of incontinence for R37 and established a baseline. The DON stated a comprehensive assessment should be done to determine a residents individualized toileting needs, and a care plan should be developed. She stated the nursing assistants charted on continence and the information was used to determine level of assistance needed, however, the facility did not have a formal assessment to individualized toileting patterns and stated, "Most of the residents are toileted every two hours."

A facility policy labeled Community Memorial Home Bowel/Bladder Assessment dated 6/24/08, indicated, "Each resident is assessed for specific needs/problems related to elimination and an individualized plan of care is developed and implemented for each resident based on the

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F 315	Continued From page 28 results of the assessment." The policy further indicated if a resident had successfully toileted sixty five percent of the time he/she will be a candidate for re-training, and a four day collection of elimination will be initiated upon admission and quarterly.	F 315		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure mechanical stand harnesses were used in accordance with manufacturer guidelines to reduce the risk of injury to residents and staff which had potential to affect 9 of 9 residents (R9, R28, R24, R32, R42, R38, R10, R36, and R3) who used a mechancial stand for transfers. In addition, the facility failed to comprehensively assess and develop interventions to reduce the risk of falls for 1 of 3 residents (R37) reviewed for accidents and who had multiple falls in the bathroom. Findings include: During initial tour of the facility on 10/12/15, at 9:09 a.m. the West Wing of the facility had a green and tan colored EZ Way (a manufacturer of	F 323	F323 - Free of Accident Hazards/Supervision/Devices - Residents affected by this deficient practice were audited on 11/5/15 to ensure that the slings used were in accordance with manufactures guidelines. All were found to be using approved slings. By 11/5/15, all stand-up lifts were specifically labeled to require that brand name slings were matched with the lift bearing that brand. The action that was taken immediately to correct this deficient practice eliminated the possibility of other residents having the potential to be affected. To ensure that this deficient practice does not happen again in the future, the mechanical lift policy will be updated and reviewed by all nursing staff at their	11/24/15

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F 323	Continued From page 29 mechanical stand equipment) mechanical stand in the hallway available for resident use. The mechanical stand had a blue and yellow colored harness draped over top which was labeled, "MedCare [a different manufacturer of mechanical stand equipment]." The East Wing had two MedCare mechanical stands in the hallway available for resident use. Each of the stands had EZ Way harness' draped over the top of them. On 10/13/15, at 11:39 a.m. the mechanical stands remained on the West and East wings with the same differing manufacturer harnesses draped over the top of the Mechanical stands. During observation of a resident transfer, R9, on 10/13/15, at 12:42 p.m. nursing assistant (NA)-A wheeled a MedCare brand mechanical stand with a EZ Way harness draped over top of it into R9's room. NA-A placed the EZ Way harness around R9 and secured to the MedCare mechanical stand. R9 was assisted to stand using the device and harness then assisted to the restroom. At 12:51 p.m. NA-A opened R9's door and placed the MedCare mechanical stand with the EZ Way harness draped over the top back into the hallway, available for further resident use. During interview on 10/13/15, at 12:52 p.m. NA-A stated R9, R28, R24, R32, and R42 all reside on the East Wing and use the mechanical stands to transfer. NA-A stated she was not aware why the mechanical stand harnesses were switched and placed on the MedCare brand mechanical stands, but stated staff normally try to keep them,"On the right machine." NA-A stated she was unaware if the EZ Way harnesses were interchangeable with the MedCare harnesses.	F 323	meeting on November 19, 2015. In addition, it was brought to the attention of IDT on 11/10/15 and will a scheduled discussion point at the Board of Directors meeting on 11/12/15 and at the next quarterly QA meeting. Sling inventories were checked and additional slings ordered on 11/11/15 to ensure adequate availability for each brand of lift. To monitor the effectiveness of corrective actions taken, five (5) random audits checking for proper sling usage will be completed by licensed staff weekly beginning 11-9-15 and continuing for 12 weeks on residents using mechanical standing lifts. Regarding R37 within this tag, a fall assessment was completed on 11/6/15 and the collection of bowel and bladder data was started on 11/2/15 with that assessment being completed on 11/6/15. Resident #37 was seen by therapy from 10/13/15 until 11/6/15 to see if strength and balance could be improved. On 10/20/15 and as a result of additional QA planning, the resident agreed to try using a timer in her bathroom so that she would be reminded of how long she has been in the bathroom. R37□s care plan was updated on 10/16/15 to require that staff stay with the resident while she is in the bathroom. An alarm policy was created on 11/9/15 which specifies that residents with chair alarms not be left unattended while in the bathroom. To prevent this deficient practice from happening again, care plans for all residents who have chair alarms were reviewed and updated to reflect this policy. The alarm policy will be reviewed	

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F 323	Continued From page 30 During interview on 10/13/15, at 1:01 p.m. NA-F stated R38, R10, R36, and R3 all reside on the East Wing and use the mechanical stands to transfer. NA-F observed the mechanical stands in the hallway and stated the harnesses were interchangeable and used to transfer residents just as they are sitting in the hallway. NA-F stated the mechanical stands had been used in this manner since she had started with the facility about a year ago. NA-F stated she had received training on how to use the mechanical stands upon her hire to the facility, and she had never been told if the harnesses were able to be used interchangeably. During interview on 10/13/15, at 4:59 p.m. licensed practical nurse (LPN)-A stated the mechanical stands should be, "Color coordinated" with the harnesses, and the EZ Way harnesses should only be used with the EZ Way mechanical stands. LPN-A stated the harnesses are not considered to be interchangeable, and using them as they had been observed in the hallway, "Could cause a problem that could potentially hurt a resident." During interview on 10/14/15, at 8:21 a.m. an EZ Way representative stated the EZ Way harnesses are built for and tested only with an EZ Way mechanical stand, and the harnesses should only, "Be used with our equipment." The mechanical stand industry was still trying to develop a universal sling, but one had not been approved for use yet. Further, the representative stated the devices were not considered to be interchangeable, "I can only recommend using our slings and harnesses with our equipment." The EZ Way Smart Stand Operator's Instructions	F 323	by all nursing staff at their meeting scheduled for November 19, 2015. The incident/accident form were updated to include assessment and treatment prompts. The Administrator and DON will sign off each time this form is completed. Completion Date: November 24, 2015	

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dated 6/17/14, identified, "EZ Way harnesses are made specifically for EZ Way stands. For the safety of the patient and caregiver, only EZ Way harnesses should be used with EZ Way stands."

During interview on 10/14/15, at 8:45 a.m. the director of nursing (DON) stated she believed the harnesses and mechanical stands were interchangeable and were being used in that manner to transfer residents. Further, the DON stated the facility, "Never had a problem" using them interchangeably.

R37's quarterly Minimum Data Set (MDS) dated 9/10/15, indicated the resident was cognitively intact, and required assistance with transfers and toileting.

R37's Care Area Assessment dated 4/10/15, indicated R37 was at risk for falls related to difficulty maintaining sitting balance, impaired balance during transfers, medication use, loss of arm or leg movements, and urinary and bowel incontinence.

R37's care plan dated 9/25/15, indicated R37 required assistance with all activities of daily living, and was at risk for falls characterized by history of falls/injury. The care plan directed staff to analyze previous falls to determine whether a pattern/trend could be addressed. The care plan further directed staff to keep call light in reach and remind her to call for assistance, reinforce need to call for assistance, and wear proper foot wear. R37's care plan for toileting directed staff to assist the resident to the toilet at her request, and every two hours. The care plan indicated, R37 "May request to sit a while," on the toilet, and

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staff was directed to use motion sensor in the bathroom doorway, remind her to use call light, allow privacy, and check on her often." Although R37 sustained multiple falls in her bathroom, the care plan did not direct staff to remain in the room with R37.

A review of facility Incident Report Review/Investigation form indicated R37 had 7 falls between 4/19/15, and 10/10/15. Five of the seven falls occurred in R37's bathroom.
On 4/19/15, R37 fell self transferring to the toilet.
On 5/10/15, R37 fell off the toilet.
On 5/14/5, R37 fell self transferring to the toilet.
On 8/10/15, R37 fell after self transferring off the toilet and ambulating independently to her sink.
On 10/8/15, R37 fell again in the bathroom after self transferring off the toilet.

Interventions immediately following the falls listed on the Incident Report Review/ Investigation form included: A narrow wheel chair that would fit through bathroom doorway, removal of over the toilet commode, tabs alarm to chair and in bathroom, keep reacher in residents reach, motion sensor in bathroom doorway, and a pressure sensor alarm in wheel chair. There was no indication the facility had reassessed R37's toileting schedule.

During observation on 10/13/15, at 6:56 p.m. a staff member was observed running down the hall in response to an alarm sounding in R37's bathroom where R37 was attempting to self transfer to the toilet.

During interview on 10/14/15, at 12:25 p.m., nursing assistant (NA)-A stated R37 liked to sit in the bathroom for a long time. NA-A stated R37

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was incontinent of bowel and bladder, and was not on a toileting plan. NA-A stated R37 forgets she needs help to go to the bathroom and had several falls attempting to toilet herself.

During interview on 10/14/15, at 12:47 p.m., registered nurse (RN)-A stated after a fall she reviewed the incident report with the interdisciplinary team and attempted to, "Identify what the issues are." RN-A stated multiple interventions had been attempted r R37's falls including A clip on alarm, a motion sensor alarm, and posting signs to remind R37 to use her call light. RN-A stated R37 was not safe to transfer in her room alone, and displayed a lack of safety awareness. However, R37's care plan directed staff to leave her alone in the bathroom and "Check on her." RN-A stated she was not aware if R37's toileting status had been reassessed in regards to her falls.

During interview on 10/14/15, at 1:07 p.m. the director of nursing (DON) stated the licensed nurses review every fall. The DON stated she was aware R37 falls in the bathroom and stated, "Unfortunately she [R37] sits for half hour to forty five minutes at a time, and we can't do a one to one with her for that long."

A document titled Community Memorial Home Policy and Procedure, Resident Incident/ Accident dated 12/14, directed staff to assess the resident after each incident and determine whether changes in the plan of care were appropriate by reviewing each incident and determining a root cause to prevent further recurrence.

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	245465	A. BUILDING _____ B. WING _____	10/15/2015

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COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

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F 323	Continued From page 34	F 323		
F 327 SS=D	. 483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 residents (R1) who developed nausea and vomiting was comprehensively re-assessed to determine current fluid needs to prevent potential dehydration. Findings include: R1's most recent Prospective Payment System (PPS) Minimum Data Set (MDS) dated 9/11/15, identified R1 had no cognitive impairment, and required set up assistance with eating. R1's Nutrition Risk Assessment dated 8/3/15, identified R1 was not on a fluid restriction, and consumed 1500 to 2000 ml (milliliters) of fluid on a daily basis. R1's nutrition progress note dated 8/7/15, identified R1 had been assessed to require 2425 ml of fluid on a daily basis, and added, "He is meeting his assessed needs." An additional	F 327	F327 - Sufficient Fluid to Maintain Hydration The affected resident (#1) had a new nutrition assessment completed by the Dietary Manger on October 14, 2015. Corresponding updates have been made to the Care Plan and these were reviewed by the Registered Dietician on 10/14/15. The Dietary Manager, Director of Nursing, and RN Case Managers will ensure that all residents with nausea and vomiting longer than 3 days will be put at high hydration risk and encourage fluids to 35 ml/kg body weight until signs and symptoms resolve. Dietary Manger will re-assess current fluid needs in the nutrition assessment. A fluid plan will be put in place to encourage fluid to the 35ml/kg body weight and added to care plan along with nursing information for continued compliance. The Registered Dietician assisted with the revision of the Hydration policy. Changes to this policy will be	11/24/15

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F 327	Continued From page 35 nutrition note by the registered dietician (RD)-A, dated 9/24/15, identified R1 to be "at high nutritional risk" related to several factors including "emesis and nausea and poor intake of food", and RD-A would "continue to follow once returns from hospital." During observation of the supper meal on 10/13/15, at 5:40 p.m. R1 was laying in bed in his room. Nursing assistant (NA)-G served R1 a tray of food with a coffee cup of hot water with a packet of hot chocolate mix, a 240 ml glass of milk, and a 240 ml glass of water. At 6:26 p.m. R1 had a light green colored emesis basin on his bed which contained approximately 100 ml of light brown emesis in the basin. R1 stated he had been having emesis for "about a month." R1 had completed his meal, and only consumed approximately 180 ml of his provided milk, and 100 ml of his hot chocolate. During interview on 10/13/15, at 6:50 p.m. NA-G stated R1 had been having emesis for the past "three or four weeks", but was unsure of the cause. During interview on 10/13/15, at 6:53 p.m. NA-E stated residents with room trays have their intakes recorded by kitchen staff, but was unsure how R1's fluid intake was monitored. R1's care plan dated 9/18/15, identified R1 was independent with eating, and listed an intervention of, "Food and Fluid Intake." However, the care plan lacked any information on how much fluid R1 should consumed to ensure adequate hydration, or any monitoring for potential signs and symptoms of dehydration for R1.	F 327	reviewed with QA and IDT teams at their next scheduled meetings. High Hydration risk residents will be reviewed daily by Dietary Manager and will be discussed at daily stand up meetings, weekly IDT meetings and reviewed with the QA team to evaluate compliance with facility policy. The Director of Nursing will audit work done by the Dietary Manger weekly for one full quarter to ensure that the policy is adhered to. Completion Date: November 24, 2015	

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F 327	Continued From page 36	F 327		

R1's Food and Fluid Intake charting dated 9/15/15, to 10/13/15, identified the fluids consumed by R1 at meals with four options to record results including the following:
> "Amount"
> "Resident Not Available"
> "Resident Refused"
> "Not Applicable"

R1's highest recorded fluid intake was on 9/26/15, when he consumed 1600 ml of fluid (825 ml less than his assessed needs as of 8/7/15). The other recorded intakes for R1 ranged from 330 ml on 9/19/15, to 1440 ml on 10/7/15, all of which were below R1's assessed fluid needs of 2425 ml per day. In addition, R1 had seven meals documented as "Resident Refused," and two meals recorded as "Not Applicable." The charting did not identify any alternatives offered to R1 for his refusals of fluid.

When interviewed on 10/14/15, at 9:21 a.m. the certified dietary manager (CDM) stated R1 was currently assessed to require 2425 ml of fluid as identified in his initial progress note. R1 was at risk for dehydration because of his developed nausea and emesis, and the CDM added she was unsure of his current fluids needs to balance his fluid needs with the emesis he had developed in the week prior. Further, the CDM stated R1 should have been reassessed to determine his current fluid needs and to ensure he was maintaining hydration with his ongoing nausea and emesis.

During interview on 10/14/15, at 11:17 a.m. registered nurse (RN)-C stated R1 had been having bouts of nausea and emesis for "maybe a

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F 327	Continued From page 37 month." R1 was being followed by RD-A for his nutrition risk, but nursing had not been tracking "total intake" of fluids on R1 despite having developed nausea and having several emesis. When interviewed on 10/14/15, at 12:59 p.m. registered dietician (RD)-A stated R1 was at high risk of dehydration, and his repeated emesis was a concern. RD-A stated staff should ensure he receives his newly assessed fluid each day, and a plan to do that would be developed.	F 327		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of	F 431		11/24/15

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F 431	Continued From page 38 controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure medications for 3 of 10 residents (R10, R34, and R28) reviewed for medication storage were appropriately labeled to reduce the risk of administration errors. Findings include: During observation of a medication pass on 10/14/15, at 7:49 a.m. R10's artificial tears (eye lubricant) were opened and had R10's name, physician name, and expiration date. The bottle lack direction on how many drops, which eye(s), and how often to administer the artificial tears to R10. Review of R10's physician orders dated 10/15, indicated artificial tears 1 drop instilled in both eyes, two times a day for dry eyes. During interview on 10/14/15, at 7:49 a.m. licensed practical nurse (LPN)-B stated the label from pharmacy had fallen off, and a label with R10's name on it was placed on the artificial tears and the staff would finish the bottle. LPN-B stated staff checks the medication administration record (MAR) for the directions of the artificial tears.	F 431	F431 □ Drug Records, Label/Store Drugs and Biologicals - On 11/4/15 the affected resident□s medications were reviewed to ensure proper labeling. On 11/4/15 an audit of the med carts was completed by licensed staff to ensure all medication labeling complied with facility policy. On 11/3/15 the Case Manager spoke with Thrifty White Pharmacist, Ray. When a label falls off or is no longer legible the medication will be returned to the pharmacy for relabeling. RN Case Manager consulted with Jenny Konrad, Pharmacy Consultant, and reviewed current policy and procedure. The Over the Counter Medication Policy was updated on November 10, 2015. To ensure future compliance, the policy will reviewed at the nurses meeting to be held on November 19, 2015 and the DON or her designee will do 3 weekly random audits for 12 weeks to ensure medication labeling is compliant with facility policy. Audit results will be reviewed at upcoming IDT and QA meetings. Completion Date: November 24, 2015	

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F 431	Continued From page 39 On 10/14/15, at 9:24 a.m. LPN-B state a new pharmacy label had arrived from the pharmacy and was put onto R10's artificial tears. The new pharmacy label directions indicated 1-2 drops every four hours in each eye. During the east medication cart review on 10/15/15, at 9:32 a.m. R34's aspercreme (pain relieving) lotion label had R34's name on the label. The bottle lacked when to apply, where to apply, and how often to apply the aspercreme lotion. R34's physician's orders for 10/15, indicated BenGay (pain relieving) (or equivalent) topically (applied to skin surfaces), apply three times a day to affected areas. During interview on 10/15/15, at 9:41 a.m. LPN-A staff will look at the MAR to get the directions for the aspercreme. The east medication cart also contained R28's systane (eye lubricant) directions which indicated to instill 2-3 drops into both eyes every morning. The label lacked the appropriate number of drops of systane to instill. R28's physician orders for 10/15, directed staff to instill two drops in both eyes, four times a day as needed for dry, irritated eyes. The facility policy titled Over the Counter Medications dated 10/11/08, indicated medications must have a label on it.	F 431		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABL	F 465		11/24/15

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F 465	Continued From page 40 E 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 a wheelchair was kept in a good and clean condition for 1 of 1 residents (R46) observed to have a wheelchair in disrepair. Findings include: R46's quarterly Minimum Data Set (MDS) dated 8/27/15, identified R46 had moderate cognitive impairment, and used a wheelchair for mobility. During observation on 10/12/15, at 2:10 p.m. R46's wheelchair was in his room. The wheelchair had pink tape wrapped around the right brake handle which was visibly soiled with a dark colored substance. On 10/13/15, at 11:49 a.m. R46 was seated in his wheelchair in the dining room and his wheelchair continued to have the soiled, pink tape on the right brake handle. During interview on 10/15/15, at 8:27 a.m. R46 stated he was unaware why his wheelchair had the soiled pink tape on the right brake handle. During interview on 10/15/15, at 8:28 a.m. nursing assistant (NA)-D stated staff used the brakes and touch the soiled pink taped handle on	F 465	F465 Safe/Functional/Sanitary/Comfortable Environment - Pink tape was removed from the affected resident's (R46) wheelchair on 10/15/15. The wheelchair brake handle was replaced on 10/15/15. A thorough wheelchair washing was completed on 10/15/15. During the week of 11/2 /15 11/6/15 and in order to identify other residents who might be affected by this deficient practice, all resident wheelchairs were audited by the Maintenance Director to ensure they met cleanliness standards per policy. The wheelchair policy was updated and reviewed by housekeeping staff as of October 23, 2015. The revised wheelchair policy will be reviewed at the full staff meeting scheduled for November 20, 2015. Minutes of this meeting will be available to staff that were unable to attend. To ensure ongoing compliance, the Maintenance Director will audit 5 random wheelchairs weekly for 12 weeks. Completion Date: November 24, 2015.	

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F 465	Continued From page 41 R46's chair when they assist him with wheeling around the facility. NA-D stated she was unaware how often wheelchairs were cleaned or inspected, and added the soiled tape should not be on R46's wheelchair. During interview on 10/15/15, at 8:33 a.m. housekeeping aide (HA)-A stated they were responsible to clean and maintain the wheelchairs for the residents. The wheelchairs were being cleaned "twice every month," and R46's wheelchair was last cleaned on 10/9/15. At 8:36 a.m. HA-A observed the soiled pink colored handle of R46's wheelchair, and removed the soiled tape around the handle, which exposed a piece of pink paper and a ripped foam handle which HA-A stated appeared to be, "Getting worse." HA-A stated staff should have filled out a maintenance slip for R46's wheelchair when the handle broke versus taping it up and allowing it to become dirty and an uncleanable surface. An undated facility policy titled Wheelchair Washing identified staff were to, "Note and report any torn, worn, or missing parts from the wheelchair by filling out a maintenance request slip." The facility was unable to provide any maintence request slip that had been filled out requesting to repair R46's wheelchair.	F 465		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of	F 520		11/24/15

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F 520	Continued From page 42 nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the Quality Assessment & Assurance (QA&A) committee developed, implemented, and re-evaluated action plans to reduce falls for 1 of 3 residents (R37) reviewed for accidents and who had multiple falls. This practice had potential to affect all residents who had, or could have, sustain multiple falls. Findings include: R37's quarterly Minimum Data Set (MDS) dated 9/10/15, indicated the resident was cognitively intact, and required assistance with transfers and toileting.	F 520	F520 □ QAA Committee Members/Meet Quarterly/Plans - Although the falls of R37 and their resulting trend had been previously addressed by the QA committee, recognition of this deficient practice was immediately addressed, again, by QA members on the 20th of October. Actions and interventions already tried were reviewed and new intervention(s) suggested. As a result of additional QAA attention, R37 has not fallen for over a month, since her last fall on 10-10-15. To prevent this deficient practice from happening again or to other residents, the QA committee will pay more	

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F 520	Continued From page 43 R37's Care Area Assessment dated 4/10/15, indicated R37 was at risk for falls related to difficulty maintaining sitting balance, impaired balance during transfers, medication use, loss of arm or leg movements, and urinary and bowel incontinence. R37's care plan dated 9/25/15, indicated R37 required assistance with all activities of daily living, and was at risk for falls characterized by history of falls/injury. The care plan directed staff to analyze previous falls to determine whether a pattern/trend could be addressed. The care plan further directed staff to keep call light in reach and remind her to call for assistance, reinforce need to call for assistance, and wear proper foot wear. R37's care plan for toileting directed staff to assist the resident to the toilet at her request, and every two hours. The care plan indicated, R37 "May request to sit a while," on the toilet, and staff was directed to use motion sensor in the bathroom doorway, remind her to use call light, allow privacy, and check on her often." Although R37 sustained multiple falls in her bathroom, the care plan did not direct staff to remain in the room with R37. A review of facility Incident Report Review/Investigation form indicated R37 had 7 falls between 4/19/15, and 10/10/15. Five of the seven falls occurred in R37's bathroom. On 4/19/15, R37 fell self transferring to the toilet. On 5/10/15, R37 fell off the toilet. On 5/14/5, R37 fell self transferring to the toilet. On 8/10/15, R37 fell after self transferring off the toilet and ambulating independently to her sink. On 10/8/15, R37 fell again in the bathroom after self transferring off the toilet.	F 520	attention to the existence of trends that may require the exploration of interventions in addition to those already tried. In recognition of their responsibilities for oversight and comprehensive planning, the deficient practice identified in this tag will be brought to the attention of the Board of Directors on 11-12-15 and discussed at the next quarterly QA meeting where a plan of action to correct this identified quality deficiency will be discussed and created. Additionally, the facility□s quality assurance plan will be reviewed and affirmed at those meetings. In order to ensure ongoing compliance and effectiveness of the corrections taken to address this deficient practice, the facility Administrator will, for one year, audit the various quality assurance activities that are prescribed in the facility□s QA plan for compliance, including the identification of trends that call the development of comprehensive action plans. Completion Date: November 24, 2015	

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F 520	Continued From page 44 Interventions immediately following the falls listed on the Incident Report Review/ Investigation form included: A narrow wheel chair that would fit through bathroom doorway, removal of over the toilet commode, tabs alarm to chair and in bathroom, keep reacher in residents reach, motion sensor in bathroom doorway, and a pressure sensor alarm in wheel chair. There was no indication the facility had reassessed R37's toileting schedule. During observation on 10/13/15, at 6:56 p.m. a staff member was observed running down the hall in response to an alarm sounding in R37's bathroom where R37 was attempting to self transfer to the toilet. During interview on 10/14/15, at 12:25 p.m., nursing assistant (NA)-A stated R37 liked to sit in the bathroom for a long time. NA-A stated R37 was incontinent of bowel and bladder, and was not on a toileting plan. NA-A stated R37 forgets she needs help to go to the bathroom and had several falls attempting to toilet herself. During interview on 10/14/15, at 12:47 p.m., registered nurse (RN)-A stated after a fall she reviewed the incident report with the interdisciplinary team and attempted to, "Identify what the issues are." RN-A stated multiple interventions had been attempted r R37's falls including A clip on alarm, a motion sensor alarm, and posting signs to remind R37 to use her call light. RN-A stated R37 was not safe to transfer in her room alone, and displayed a lack of safety awareness. However, R37's care plan directed staff to leave her alone in the bathroom and "Check on her." RN-A stated she was not aware	F 520		

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F 520	Continued From page 45	F 520		

if R37's toileting status had been reassessed in regards to her falls.

During interview on 10/14/15, at 1:07 p.m. the director of nursing (DON) stated the licensed nurses review every fall. The DON stated she was aware R37 falls in the bathroom and stated, "Unfortunately she [R37] sits for half hour to forty five minutes at a time, and we can't do a one to one with her for that long."

When interviewed on 10/15/15, at 12:39 p.m. the administrator stated the QA&A committee is used to improve quality and services to the residents of the facility, and resident falls were frequently discussed at the quarterly meetings. The QA&A committee was "well aware" of, and had identified R37 as a resident who had sustained frequent falls, though "fortunately without injury." The administrator stated the facility board of directors were also aware of R37's frequent falls, but no formal action plans outside the care plan had been developed to reduce the risk of falls for R37 despite being identified, but rather allowing the care planning process to address R37's risk for continued falls adding, "I think that is the best process to pursue that."

A facility Quality Assurance Plan policy dated 10/2015, identified, "The purpose of Community Memorial Home's Quality Assurance [QA] Program is to provide a comprehensive plan designed to ensure that the quality and quantity of care given to each resident is optimal..." Further, the policy identified, "The Quality Assurance Committee will meet at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary. The Committee will develop and implement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING _____ B. WING _____	10/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

(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 520	Continued From page 46 appropriate plans of action to correct identified quality deficiencies."	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/20/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET** **OSAKIS, MN 56360**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 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, the 1963 and 1977 sections of Community Memorial Home were 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/11/2015

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

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K 000	Continued From page 1 By e-mail to: Marian.Whitney@state.mn.us or 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. This facility was surveyed as two separate buildings. Community Memorial Home is a 2 story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1963, is one story and was determined to be of Type II(000) construction. In 1977, a one story, Type II(000), expansion to the dining room was added. Because the original 1963 building and the 1977 addition meet the construction type allowed for existing buildings, these buildings were surveyed as one existing building. The 2 story 2008 Wellness Center addition was surveyed as new construction. The building is fully fire sprinklered throughout. The facility has a fire alarm system that includes smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a census of 39	K 000		

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K 000	Continued From page 2 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observations and an interview, it was revealed that the facility is using the corridors as part of the air distribution system to provide make-up air for the sleeping rooms' bathroom exhaust, throughout the building which is not in accordance with NFPA 90A. This deficient practice could allow the products of combustion to travel far from the fire origin and negatively affect all residents, staff and visitors by restricting their means of egress in a fire situation.. Findings include: On facility tour between 1:30 PM and 4:30 PM on 10/20/2015, the following deficient conditions were found affecting the facility's HVAC system: 1. An interview with the Facility Administrator (DC), a review of documentation and observations revealed that the HVAC systems for all wings of the 1963 and 1977 additions have ducted air supply to the corridors and no return or	K 067	K 067 A waiver continuation for K 067 has been requested for which justification dated 11-02-15 on form CMS 2786R was attached. In addition, by 11-24-15, the Director of Environmental Services will inspect and test the fire and smoke dampers in our buildings to ensure their proper operation so that smoke migration does not negatively affect the safety of residents, staff, and visitors in the event of a fire. To ensure future compliance the FIRE/SMOKE DAMPER MAINTENANCE RECORD will be completed and signed upon each annual inspection by both the Director of Environmental Services and the Administrator. Completion Date: November 24, 2015	11/24/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 067	Continued From page 3 exhaust from the corridors. There is no supply or return in the resident rooms, which all have bathroom exhaust fans that are constantly exhausting to the outside. This situation is using the corridors as a supply plenum. 2. It was revealed during the review of the facility's fire and smoke damper test/inspection documentation and was confirmed by interview with the Environmental Services (TM), that the facility could not provide any documentation verifying that the fire and smoke dampers have been tested/inspected within the last 4 years. This was confirmed by the Director of Environmental Services (TM). An annual waiver has been previously granted.	K 067		
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observations the facility failed to keep the means of egress continuous and free of all obstructions or impediments to full instant use in the case of fire or other emergency, in accordance with NFPA Life Safety Code 101	K 072	K 072 By 11-01-15 or sooner, the Director of Environmental Services will remove exercise equipment from the exit stairwell and corridors leading to the exit stairwell and lifts, wheel chairs, and carts from the	11/24/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 072	Continued From page 4 (2000 edition) Chapter 7, Section 7.1.10. These obstructions could interfere with the convenient and effective removal all residents, staff and visitors in an emergency situation, and impede fire fighting operations during a fire emergency. Findings include: On facility tour between 1:30 PM and 4:30 PM on 10/20/2015 during the facility tour it was observed that in the west corridor there were multiple lifts, wheel chairs and cart in the corridor. This was confirmed by the Director of Environmental Services (TM).	K 072	west corridor that were found to be obstructing egress from the building(s). The Director will then, by 11-01-15 or sooner, inspect all other means of egress from the buildings to ensure that they are free of obstructions or impediments to full instant use in the case of fire or other emergency. To ensure future compliance, the Director of Environmental Services will monitor each and every egress from all buildings whenever he is on duty. The facility Administrator and Director of Environmental Services will verify through his/her signature that this corrective action has been taken and that it is sustained on a monthly basis. Completion Date: November 24, 2015	

Name of Facility **2000 CODE**

Community Memorial Home at Osakis, MN Inc. dba Galeon

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84 K067 Heating, Ventilation and Air Conditioning (HVAC) equipment at CMH does not comply with LSC (00) Section 9.2 and NFPA 90A, 1999 Edition because the corridors are used as a plenum.	A continuing waiver is being requested for K067 for the following reasons: A. An extreme financial hardship on Community Memorial Home (CMH) will result from compliance because: 1. 11-2-15 estimates for compliance (attached) with NFPA 90A show that it will cost between $463,965 and $608,264. Funding for this expense is not available under current reimbursement rules; 2. The electrical system at CMH would need to be modified at a cost that may exceed $38,617; 3. Asbestos abatement required during installation would cost between $61,862 and $85,995; and 4. Non-complying systems are allowed to be used under LSC(00), 9.2.1. B. If this waiver is approved, the safety of building occupants will not be compromised because: 1. CMH was built under Type II construction standards; 2. Walls, floors, ceilings and vertical openings at CMH already resist the passage of smoke; 3. CMH is completely protected by a supervised sprinkler system installed in accordance with NFPA 13; 4. HVAC ventilation fans automatically shut down upon fire alarm activation or the detection of smoke; 5. Resident sleeping rooms are all equipped with single station battery operated smoke detectors; 6. The property of CMH is smoke and tobacco free with signs posted to that effect; 7. All CMH corridors are equipped with a compliant UL listed smoke detection system; 8. The local fire department is located 6 blocks away and will respond to an alarm in less than 10 mins; 9. CMH has an approved fire safety plan and is compliant with all other fire safety requirements; and 10. A continuing waiver has been approved annually in the past for Community Memorial Home. Requested by: David E. Carlson, Admin. 11-9-15 David E. Carlson, Administrator 11-09-2015

Surveyor (Signature)	Title	Office	Date
[signature]	FIRE SAFETY SUPERVISOR	STATE FIRE MARSHAL	11/12/2015
Fire Authority Official (Signature)	Title	Office	Date

morton
CONSTRUCTION MANAGERS

3315 Roosevelt Road • Suite 100
St. Cloud, MN 56301
Bus 320.251.0262
Fax 320.251.5749
www.ramorton.com

November 2, 2015

Dave Carlson, Administrator
Galeon
410 West Main Street
Osakis, MN 56360

Dear Dave,

Per our conversation on Friday, October 30, 2015, costs for complying with NFPA 90A are shown in the Preliminary Master Budget that is attached. Please consider the high and low ranges provided in the budget to be our current estimate of cost.

Thank you.

Sincerely,

Preston Euerle
President/CEO

PRELIMINARY MASTER BUDGET
Galeon - Community Memorial Home
PREPARED: 11/2/2015

morton
CONSTRUCTION MANAGERS
"right from the start"
3315 Roosevelt Road, Ste. 100
St. Cloud MN 56301
Bus. (320) 251-0262 Fax: (320) 251-5749

	Low Range 24,000 S.F. DOLLARS		High Range 24,000 S.F. DOLLARS	
I. LAND				
SUBTOTAL LAND	$ -		$ -	
II. CONSTRUCTION COSTS				
GENERAL CONDITIONS	$ 27,583	$ 1.15	$ 34,070	$ 1.42
INTERIOR FINISHES / DEMO	$ 19,860	$ 0.83	$ 30,663	$ 1.28
MECHANICAL	$ 211,841	$ 8.83	$ 272,563	$ 11.36
FIRE SPRINKLER	$ 5,517	$ 0.23	$ 11,357	$ 0.47
ELECTRICAL	$ 38,617	$ 1.61	$ 45,427	$ 1.89
CONTINGENCY	$ 31,200	$ 1.30	$ 39,900	$ 1.66
SUBTOTAL CONSTRUCTION COSTS	$ 334,617	$ 13.94	$ 433,981	$ 18.08
III. SOFT COSTS				
FEES / PERMITS / PRINTING	$ 67,486	$ 2.81	$ 88,288	$ 3.68
OTHER	$ -	$ -	$ -	$ -
SUBTOTAL SOFT COSTS	$ 67,486	$ 2.81	$ 88,288	$ 3.68
IV. OWNER ITEMS				
FURNITURE/FIXTURES/EQUIPMENT	$ -		$ -	
OTHER - ASBESTOS ABATEMENT	$ 61,862	$ 2.58	$ 85,995	$ 3.58
SUBTOTAL OWNER ITEMS COSTS	$ 61,862	$ 2.58	$ 85,995	$ 3.58
V. TOTAL PROJECT COST	$ 463,965	$ 19.33	$ 608,264	$ 25.34

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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, the 1963 and 1977 sections of Community Memorial Home were 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) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/11/2015

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

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K 000	Continued From page 1 By e-mail to: Marian.Whitney@state.mn.us or 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. This facility was surveyed as two separate buildings. Community Memorial Home is a 2 story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1963, is one story and was determined to be of Type II(000) construction. In 1977, a one story, Type II(000), expansion to the dining room was added. Because the original 1963 building and the 1977 addition meet the construction type allowed for existing buildings, these buildings were surveyed as one existing building. The 2 story 2008 Wellness Center addition was surveyed as new construction. The building is fully fire sprinklered throughout. The facility has a fire alarm system that includes smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a census of 39	K 000		

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K 000	Continued From page 2 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 9.2, 18.5.2.1, 18.5.2.2, NFPA 90A This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the fire/smoke damper system has not been maintained in accordance with the requirements of NFPA 90(99) section 3-4.7. This deficient practice does not ensure the proper operation of the fire/smoke dampers and could allow smoke migration to negatively affect the safety of all residents, staff and visitors in the event of a fire. Findings include: On facility tour between 1:30 PM and 4:30 PM on 10/20/2015, it was revealed during the review of the facility's fire and smoke damper test/inspection documentation and was confirmed by interview with the Environmental Services (TM), that the facility could not provide any documentation verifying that the fire and smoke dampers have been tested/inspected within the last 4 years.	K 067	K 067 A waiver continuation for K 067 has been requested for which justification dated 11-02-15 on form CMS 2786R was attached. In addition, by 11-24-15, the Director of Environmental Services will inspect and test the fire and smoke dampers in our buildings to ensure their proper operation so that smoke migration does not negatively affect the safety of residents, staff, and visitors in the event of a fire. To ensure future compliance the FIRE/SMOKE DAMPER MAINTENANCE RECORD will be completed and signed upon each annual inspection by both the Director of Environmental Services and the Administrator. Completion Date: November 24, 2015	11/24/15

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K 067	Continued From page 3 This was confirmed by the Director of Environmental Services (TM).	K 067		
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observations the facility failed to keep the means of egress continuous and free of all obstructions or impediments to full instant use in the case of fire or other emergency, in accordance with NFPA Life Safety Code 101 (2000 edition) Chapter 7, Section 7.1.10. These obstructions could interfere with the convenient and effective removal all residents, staff and visitors in an emergency situation, and impede fire fighting operations during a fire emergency. Findings include: On facility tour between 1:30 PM and 4:30 PM on 10/20/2015 during the facility tour it was observed that in the exit stairwell and the corridors leading to the exit stairwell there were several pieces of exercise equipment i.e. treadmills obstructing the egress path. This was confirmed by the Director of	K 072	K 072 By 11-01-15 or sooner, the Director of Environmental Services will remove exercise equipment from the exit stairwell and corridors leading to the exit stairwell and lifts, wheel chairs, and carts from the west corridor that were found to be obstructing egress from the building(s). The Director will then, by 11-01-15 or sooner, inspect all other means of egress from the buildings to ensure that they are free of obstructions or impediments to full instant use in the case of fire or other emergency. To ensure future compliance, the Director of Environmental Services will monitor each and every egress from all buildings whenever he is on duty. The facility Administrator and Director of Environmental Services will verify through his/her signature that this corrective action has been taken and that it is sustained on a monthly basis. Completion Date: November 24, 2015	11/24/15

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 072	Continued From page 4 Environmental Services (TM).	K 072		